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**Congress' Self-Inflicted Sisyphean Task: The Insurance Industry's
Federal Antitrust Exemption and the Insurance Industry
Competition Acts of 2007 and 2009**

Anthony A. Alt

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**SOLVENCY II:
THE AMBITIOUS MODERNIZATION OF THE
PRUDENTIAL REGULATION OF INSURERS AND
REINSURERS ACROSS THE EUROPEAN UNION (EU)**

*Michael J-H. Smith**

This [Solvency II] is an ambitious proposal that will completely overhaul the way we ensure the financial soundness of our insurers. We are setting a world-leading standard that requires insurers to focus on managing all the risks they face and enables them to operate much more efficiently. It's good news for consumers, for the insurance industry and for the EU economy as a whole.

Charlie McCreevy, EU
Internal Market and Services
Commissioner¹

I. INTRODUCTION

The prudential regulation of the EU insurance and reinsurance markets is poised to undergo a radical and modernizing sea change, affecting not only EU insurers,² but also those foreign insurers with operations in the EU. This transformation will come in the form of the new Solvency II regime, the overriding principles of which have been agreed among the European Commission, Parliament and Council as set forth in the Framework Directive (the “Framework Directive”) which was adopted by the European Parliament in April 2009 and subsequently adopted by the European Council on November 10, 2009.³

* Paris, France; Member of the Connecticut and New York bars; Solicitor of the Supreme Court of England and Wales.

¹ See Press Release, European Commission, ‘Solvency II’: EU to Take Global Lead in Insurance Regulation (Jul. 10, 2007), *available at* http://europa.eu/press_room/index_en.htm (Search “Solvency II”; then follow “0.9102” hyperlink).

² As a general matter, references herein to “insurance” and “insurers” include “reinsurance” and “reinsurers” respectively, unless otherwise noted.

³ See Council Directive 2009/138, art. 1, 2009 O.J. (L 335) 1 (EU), <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2009:335:FULL:EN:PDF> [hereinafter Framework Directive]. It is important to point out that the

Solvency II is designed to address the various shortcomings of the current Solvency I regulatory regime, a system which has been in place since the 1970's and which is widely seen as having failed to keep pace with the changing reality of the financial and insurance markets.⁴ Once fully implemented through various measures, the sweeping provisions of Solvency II are designed to establish, among other things, EU-wide capital requirements, valuation techniques and risk management standards. As a result, Solvency II is expected to foster improved protection of policyholders, stability of the financial system, modernize supervision, deepen market integration and increase the competitiveness of insurance undertakings. Moreover, considering that the EU represents the single largest market for insurance, generating approximately 37 % of worldwide total direct premiums written,⁵ Solvency II will necessarily play a significant role in shaping insurance standards on an international level.

This Article provides a survey of certain of the more significant provisions of the Solvency II regime, and by way of brief comparison, highlights certain areas of divergence from the U.S. system. In addition, this Article examines certain key difference between Solvency II and the Basel framework (the regulatory standard applicable to financial institutions),⁶ as well as addresses some of the concerns with Solvency II based on comparisons to the Basel framework.

Framework Directive has relevance to the larger European Economic Area, *See* http://ec.europa.eu/external_relations/eea.

⁴ For an overview of Solvency I, see information on the European Commission's website, http://ec.europa.eu/internal_market/insurance/solvency_i_en.htm (last visited Mar. 22, 2010) [hereinafter Solvency I].

⁵ *See* JOHN A. COOKE & HAROLD D. SKIPPER, DEP'T OF RISK MGMT. & INS., AN EVALUATION OF U.S. INSURANCE REGULATION IN A COMPETITIVE WORLD INSURANCE MARKET 3 (2008), available at http://www.rmi.gsu.edu/insurance_regulation/rel_papers/CookeSkipper_RegulationInternational.pdf [hereinafter World Insurance Market Evaluation].

⁶ *See* Bank for Int'l Settlements, Basel II Framework, <http://www.bis.org/publ/bcbs107.htm> (last visited Mar. 22, 2010); *see generally* website of the Bank for International Settlements for information as concerns Basel II, <http://www.bis.org/publ/bcbsca.htm> (last visited Mar. 22, 2010) [hereinafter BIS Website].

II. OBJECTIVES OF SOLVENCY II

A. PROTECTION OF POLICYHOLDERS AND BENEFICIARIES

As stated by the European Parliament and Council in the introduction to the Framework Directive, the overriding objective of insurance regulation and supervision, as a general matter, is to adequately protect policyholders and beneficiaries.⁷ In this regard, Solvency II is designed to ensure, among other things, the financial soundness of insurance undertakings and reduce the probability of consumer loss or market disruption, thereby reinforcing confidence in the stability of the European insurance sector.

B. FACILITATE A SINGLE MARKET IN INSURANCE

Another main objective of Solvency II is to deepen integration of the European insurance market by facilitating a single market as concerns insurance throughout the EU,⁸ “limiting the room for national discretion and national options”,⁹ making it easier for firms to do business across the EU.¹⁰ More specifically, Solvency II seeks to remedy the current situation whereby the provisions of the current insurance regulatory regime have been unevenly applied by Member States, resulting in varying regulatory requirements across the EU, undermining the internal market and hindering the activities of insurance undertakings. In this regard, the Framework

⁷ See Framework Directive, *supra* note 3, recital ¶ 16, at 3; art. 27, at 28.

⁸ See Memorandum from the European Commission, ‘Solvency II’: Frequently Asked Questions (FAQs) 1 (Jul. 10, 2007), *available at* http://ec.europa.eu/internal_market/insurance/docs/solvency/solvency2/faq_en.pdf [hereinafter FAQs].

⁹ Thomas Steffen, Chairman, Comm. of European Ins. & Occupational Pension Supervisors, Official Presentation of the Solvency II Directive in Strasbourg (Jul. 10, 2007), *available at* <http://www.ceiops.eu/media/files/speechesarticles/ThomasSteffen-KeyMessages10juli07.pdf> [hereinafter Steffen Presentation].

¹⁰ As is presently the case, and as a general matter, an undertaking which is established and authorized in one Member State may carry out, pursuant to what is commonly referred to as a “passport”, its activities in another Member State (a host Member State) on a cross-border and / or freedom of establishment basis (e.g. via a branch office) without authorization from the host Member State being required. See, e.g., Council Directive 92/49, 1992 O.J. (L 228) 1 (EC), *available at* [://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31992L0049:EN:NOT](http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31992L0049:EN:NOT).

Directive will recast and consolidate fourteen existing directives applicable to the regulation of the insurance market into a single risk-sensitive EU-wide framework.¹¹

It is worth briefly pointing out here that, as a general matter and by way of comparison, in the U.S., the individual states, rather than the federal government, are the principle regulators of insurance activities.¹² In this regard, truly uniform insurance regulations do not apply across the U.S., resulting in rather important regulatory variations among states (a discussion of which is beyond the scope of this Article).¹³ In response to the lack of harmonization in this area, among other actual and proposed measures,¹⁴ the National Association of Insurance Commissioners (NAIC), a voluntary organization of state insurance commissioners, has promulgated various model laws, regulations and standards which have been adopted, to varying degrees, among states.¹⁵ In particular, the NAIC has initiated a financial regulation standards and voluntary accreditation program for state regulators in an effort to help establish regulatory cohesiveness on a national level.¹⁶

C. IMPROVE COMPETITIVENESS

Another key objective of Solvency II is to improve competitiveness of the insurance industry across Europe, fostering product innovation and

¹¹ See Framework Directive, *supra* note 3, recital ¶ 1, at 1.

¹² See, e.g., 1 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE § 2:2 (3d ed. 2009); Joseph F. Zimmerman, *Dual Insurance Regulation: Is It Desirable?*, 27 J. INS. REG. 3 (2008); Elizabeth F. Brown, *The Development of International Norms For Insurance Regulation*, 34 BROOK. J. INT'L L. 953 (2009) [hereinafter Development of International Norms].

¹³ See Development of International Norms, *supra* note 12, at 981-82. See generally World Insurance Market Evaluation, *supra* note 5.

¹⁴ See, e.g., THE DEP'T OF THE TREASURY, BLUEPRINT FOR A MODERNIZED REGULATORY STRUCTURE 126-28 (2008), available at <http://www.treas.gov/press/releases/reports/Blueprint.pdf>. See e.g., Press Release, The Dep't of the Treasury, Fact Sheet: Treasury Releases Blueprint for a Stronger Regulatory Structure (Mar. 31, 2008), available at http://www.treas.gov/press/releases/reports/Fact_Sheet_03.31.08.pdf.

¹⁵ See BLUEPRINT FOR A MODERNIZED REGULATORY STRUCTURE, *supra* at 9-13.

¹⁶ See NAT'L ASSOC. INS. COMM'RS, FINANCIAL REGULATION STANDARDS AND ACCREDITATION PROGRAM (2009), available at http://www.naic.org/documents/committees_f_FRSA_pamphlet.pdf.

helping to put downward pressure on prices.¹⁷ In this regard, and as discussed elsewhere herein, Solvency II aims to reflect a “principle of proportionality” as concerns, for example, the impact of related requirements on small and medium-sized undertakings, as well as the exercise of supervisory powers.¹⁸

D. PROMOTE BETTER REGULATION

Mindful of lessons learned from the financial crisis, as discussed further below, Solvency II continues to be developed as a tool to promote better regulation of the insurance industry throughout Europe by applying modern risk management and governance standards as well as implementing an early warning system for market supervisors, all as discussed in more detail below.¹⁹

III. SCOPE OF APPLICABILITY OF SOLVENCY II

Solvency II markedly expands the scope of undertakings covered beyond those currently subject to the provisions of Solvency I. In this regard, the new framework is to apply to most EU insurers and those non-EU insurers with activities in the EU.²⁰ Only those undertakings which meet certain limited conditions, including having € 5,000,000 or less in annual gross written premium income, would be exempt from the

¹⁷ See FAQs, *supra* note 8, at 2.

¹⁸ See Framework Directive, *supra* note 3, recital ¶ 19, at 3; art. 29, at 28.

¹⁹ *Id.* art. 29, at 28. See COMM. OF EUROPEAN INS. & OCCUPATIONAL PENSIONS SUPERVISORS, LESSONS LEARNED FROM THE CRISEIS (SOLVENCY II AND BEYOND), CIELOPS-SEC-107/08 (2009), available at <http://www.cielops.eu/media/files/publications/reports/CIELOPS-SEC-107-08-Lessons-learned-from-the-crisis-SII-and-beyond.pdf>.

²⁰ As concerns non-life insurance, the Framework Directive shall apply to those activities described on part A of Annex I to the Framework Directive (see Framework Directive, *supra* note 3, art. 2(2), at 18, and those non-life operations which are exempt from the scope of the Framework Directive are set forth in Article 5. *Id.* Art. 5, at 19.

Those life insurance operations subject to the Framework Directive are set forth in Article 2 (3). *Id.* at 18.

The Framework Directive will not apply, for example, to reinsurance undertakings which by December 10, 2007 have ceased doing new business and are in run-off. *Id.* art. 12, at 21.

provisions of Solvency II.²¹ However, such excluded undertakings may nevertheless elect to opt-in to the provisions of Solvency II.²²

By way of exclusion, Solvency II will not apply to insurance guarantee schemes, pension funds covered by Directive 2003/41/EEC, credit institutions or financial conglomerates.²³

IV. LEGISLATIVE STRUCTURE OF SOLVENCY II

It is important to briefly understand the legislative Process which is applicable to Solvency II. The regime is being adopted in accordance with the Lamfalussy process, a framework designed to facilitate consistent harmonization, often employed in the area of legislation applicable to the financial services sector.²⁴

A significant characteristic of the Lamfalussy process is the involvement of a committee of supervisors who work in consultation with businesses, consumers and other stakeholders.²⁵ As applies to Solvency II, this is the Committee of European Insurance and Occupational Pensions Supervisors ("CEIOPS"), a group composed of high level representatives from each of the Member States' insurance and occupational pensions supervisory authorities, as well as authorities of the Member States.²⁶

As a brief overview, the Lamfalussy process is comprised of the following four distinct levels:²⁷

Level 1: Level 1 includes the European legislative instrument, in the form of the proposed Framework Directive, which sets forth the various principles. The Framework Directive was proposed by the European Parliament and the Council

²¹ *Id.* art. 4(1), at 19.

²² *Id.* art 4(5), at 19.

²³ See FAQs, *supra* note 8, at 2.

²⁴ See European Commission, *Lamfalussy Process*, http://ec.europa.eu/internal_market/insurance/solvency/lamfalussy_en.htm (last visited Mar. 24, 2010).

²⁵ See *id.*

²⁶ See Commission Decision 2004/6, arts. 1-3, 2004 O.J. (L 3) 30, 30 (EC), *repealed by*, Commission Decision 2009/79, recital 1, 2009 O.J. (L 25) 28, 28 (EC) (establishing The Committee of European Insurance and Occupational Pensions Supervisors (CEIOPS)).

²⁷ See Comm. of European Ins. & Occupational Pensions Supervisors, CEIOPS Comments to the Lamfalussy Review, at 6, CEIOPS Doc. 20/07 (Nov. 1, 2007), available at http://www.ceiops.eu/media/docman/public_files/publications/lettersofcomments/CEIOPSCommentstotheLamfalussyReview.pdf.

pursuant to Article 251 (2) of the European Community Treaty, which provides for a co-decision process, and, as discussed above, the Framework Directive has now been formally adopted.²⁸

The Framework Directive is not directly applicable within the domestic legal orders of Member States and only provides objectives and goals that each Member State must implement through laws and / or regulations at a national level.²⁹ Therefore, Directives prove to be somewhat of a flexible instrument. In this regard, they leave room for interpretation and adaptation by each Member State, and can create uncertainty as to the speed, extent and consistency of their implementation within each Member State.³⁰ Such concerns are addressed, in part, by directly applicable Level 2 measures under the Lamfalussy process.

Level 2: Level 2, which is the current focus of the European Commission, includes various measures to supplement, and render operational, the Framework Directive.³¹ Such measures will include further directives, and in addition, it is expected that certain implementing measures will be taken in the form of regulations which are directly applicable, meaning that they create law which takes immediate effect in the same manner as a national instrument, without additional steps being required on the part of the national authorities.³² As a result, such Level 2 implementing measures should facilitate a convergence of implementation across the EU.

CEIOPS is also involved in Level 2 activities, in particular, in advising the European Commission on the drafting of specific

²⁸ Treaty on European Union, Feb. 7, 1992, 2007 O.J. (C 224) 1 [hereinafter EU Treaty]; [1992] 1 C.M.L.R. 573, 689 (incorporating changes made by EC Treaty); [1992] 1 C.M.L.R. 719; see Framework Directive, *supra* note 3; European Commission, *CO-DECISION or the "ordinary legislative procedure"*, http://ec.europa.eu/codecision/index_en.htm (last visited Mar. 24, 2010).

²⁹ See EUR-Lex, *Process and Players*, § 1.3.3, http://eur-lex.europa.eu/en/droit_communaute/droit_communaute.htm#1.3.3 (last visited Mar. 23, 2010) [hereinafter *Process and Players*].

³⁰ See *id.*

³¹ See Comm. of European Ins. & Occupational Pensions Supervisors, *List of Policy Issues and Options for the Level 2 Impact Assessment of Solvency II*, (Nov. 2009), available at http://ec.europa.eu/internal_market/insurance/docs/solvency/solvency2/list_of_policy_issues_ia_ver3_en.pdf [hereinafter CEIOPS Policy Issues and Options].

³² See *Process and Players*, *supra* note 29, § 1.3.2.

implementation measures in consultation with undertakings, market participants and other stakeholders.³³ The European Commission has committed to introducing such Level 2 implementing measures before October 2011, at least 12 months before the new system will apply to insurance undertakings.³⁴

Level 3: Level 2 implementing measures will be further supplemented by non-binding Level 3 standards and guidance. In this regard, CEIOPS will provide technical advice to the European Commission and issue supervisory standards and tools. In addition, CEIOPS will provide recommendations and guidelines in connection with the application of regulations and facilitate convergent application across Member States and cooperation among national supervisors.³⁵

Level 4: Level 4 consists of enforcement actions (e.g., legal actions) to be taken by the European Commission in respect of matters related to compliance by Member States with the various related legislative measures.

V. TIMING

The Framework Directive, and those Level 2 Directives which are eventually adopted, are to be transposed by each Member State into its national law by October 31, 2012.³⁶ In addition, directly applicable Level 2 regulations are to come into force on the same date.³⁷

It is worth noting that certain Member States such as the United Kingdom,³⁸ Denmark,³⁹ and Germany,⁴⁰ for example, have already taken

³³ See Comm. of European Ins. & Occupational Pensions Supervisors, *About CEIOPS*, <http://www.ceiops.eu/content/view/2/2> (last visited Mar. 23, 2010) [hereinafter *About CEIOPS*].

³⁴ See FAQs, *supra* note 8, at 12.

³⁵ See *About CEIOPS*, *supra* note 33.

³⁶ See Framework Directive, *supra* note 3, art. 309, at 115.

³⁷ See *id.*

³⁸ See, e.g., Financial Services Authority, www.fsa.gov.uk/ (last visited Mar. 24, 2010) (concerning the UK's Individual Capital Advisory Standards (ICAS) regime (a risk-based capital standard implemented by the FSA in 2004)).

³⁹ See, e.g., Danish FSA, <http://finanstilsynet.dk/en/Tenaer/Solvans.aspx> (last visited Mar. 24, 2010).

⁴⁰ See *Aufsichtsrechtliche mindestanforderungen an das risikomanagement* [Regulatory minimum requirements for risk management], BAFIN, Jan. 22, 2009,

steps to implement regulatory requirements in their respective jurisdictions which are founded on the same principles that underpin Solvency II.

VI. THREE PILLARS OF SOLVENCY II

One of the most significant developments of Solvency II is the introduction of a more modern economic risk sensitive-based system, based on a so-called “total balance sheet” approach where an array of risks and their interactions are taken into account.⁴¹ In this way, Solvency II marks a distinct departure from the often criticized formula-based solvency margin approach of the current Solvency I regime.⁴² In this regard, Solvency II not only takes into consideration the actual risks faced by an undertaking, but also the measures that are in place to monitor, manage and mitigate such risks. This multi-pronged approach can be divided into the following three so-called “pillars,” drawing comparisons to the similarly structured Basel framework applicable to the financial sector,⁴³ each of which is described in further detail below:

- Pillar I: Quantitative Requirements,
 - Pillar II: Governance & Risk Management Requirements,
 - Pillar III: Market Discipline and Transparency.⁴⁴
- A. PILLAR I: QUANTITATIVE REQUIREMENTS.

Solvency II introduces more sophisticated solvency requirements for insurance undertakings. While solvency requirements under the current Solvency I regime only apply in respect of insurance underwriting risks, Solvency II will also require undertakings to hold capital against market risk (e.g., risks related to the fluctuation in the level and market price of assets), credit risk (e.g., risks related to fluctuations in the credit standing of securities issuers, counterparties and / or debtors) and operational risk (e.g.,

available *at*
http://www.bafin.de/SharedDocs/Downloads/DE/Service/Rundschreiben/2009/rs_0903_mariskva,templateId=raw,property=publicationFile.pdf/rs_0903_mariskva.pdf.

⁴¹ See FAQs, *supra* note 8, at 1.

⁴² See Solvency I, *supra* note 4.

⁴³ The Basel II rules on capital requirements for banks and investment firms are implemented through the Capital Adequacy Directive. See generally Council Directive 2006/49, On the Capital Adequacy of Investment Firms and Credit Institutions (Recast), 2006 O.J. (L 177) 201 (EU).

⁴⁴ Pillars II and III are often collectively referred to as “Pillar V.”

risks related to a failure in internal processes).⁴⁵ In this regard, the solvency provisions of the Framework Directive have been developed with a view to reflecting current and proposed international solvency guidelines from the International Association of Insurance Supervisors (IAIS).⁴⁶

More specifically, the main requirements of Pillar I can be broken down as follows: (i) technical provisions; and (ii) capital requirements which include the Solvency Capital Requirement (SCR) and the Minimum Capital Requirement (MCR).

1. Technical Provisions.

As is the case under the current EU regulatory regime, undertakings will continue to be required to apply technical provisions (“reserves”) against all insurance obligations towards policyholders and applicable beneficiaries.⁴⁷

The calculation of technical provisions is to be consistent with the valuation of assets and liabilities (as described in more detail below) as well as with international developments in accounting and supervision.⁴⁸ More specifically, these reserves are based on current market transfer value (the amount an insurer would expect to pay in respect of the transfer of its insurance rights and obligations).⁴⁹ As a general matter, these provisions are to be calculated as the sum of a best estimate⁵⁰ plus a margin of risk.⁵¹ In this regard and to promote harmonization across the EU, the European Commission will be adopting implementing measures in respect of the various methodologies and standards to be adhered to in respect of the calculation of technical provisions.⁵²

⁴⁵ See, e.g., Framework Directive, *supra* note 3, recital 26, at 3; art. 100, at 51.

⁴⁶ See FAQs, *supra* note 8, at 3.

⁴⁷ See Framework Directive, *supra* note 3, arts. 76-86, at 45-48.

⁴⁸ See *id.* recital 54, at 6; arts. 77-78, at 45-46.

⁴⁹ See *id.* art. 77, at 45-46.

⁵⁰ The “best estimate” is based on a probability-weighted average of future cash flows, with regard to certain specified considerations as set forth in Article 77 of the Framework Directive. See *id.*

⁵¹ “The risk margin shall be such as to ensure that the value of the technical provisions is equivalent to the amount that insurance and reinsurance undertakings would be expected to require in order to take over and meet the insurance and reinsurance obligations.” See *id.* at 46.

⁵² See *id.* art. 86, at 47-48. By way of example, certain of the high level issues identified by CEIOPS and Commission Services for review in respect of technical provisions relate to risk margin-related calibration issues and the determination of

It is important to point out that, in a significant departure from Solvency I and as concerns insurance risks located in the EU, Member States may not require that the assets held to cover the technical provisions related to those risks be located in the EU or in any particular Member State.⁵³

2. Capital Requirements: Solvency Capital Requirement (SCR) and Minimum Capital Requirement (MCR).

Pillar I of the Framework Directive introduces two distinct, yet interconnected, capital requirements -- the Solvency Capital Requirement (SCR) and the Minimum Capital Requirement (MCR). These separate solvency requirements were created, in large part, to facilitate monitoring of insurance undertakings and to create a ladder of supervisory intervention, identifying ailing insurance undertakings before the interests of policyholders and beneficiaries are jeopardized.⁵⁴ Such intervention and each of the SCR and MCR are described in detail below.

a. *Solvency Capital Requirement (SCR).*

Undertakings are required to hold eligible own funds (as discussed further below) covering the Solvency Capital Requirement (SCR).⁵⁵ The SCR is designed to reflect a level of eligible own funds that enables undertakings to absorb significant losses and, as a result, provide reasonable assurances to policyholders and beneficiaries.⁵⁶ As such, the SCR is a risk-based calculation which takes into consideration various risks, including non-life, life and health underwriting risk (e.g., as applicable, premium, reserve, catastrophe), market risk, credit risk and operational risk (e.g., legal risk) which will impose on undertakings stricter standards as to regulatory capital.⁵⁷ The SCR will need to be calculated by undertakings at least once a year, and the results of such calculation will need to be reported to the applicable supervisors.⁵⁸

the risk-free interest rate term structure. *See also* CEIOPS Policy Issues and Options, *supra* note 31, at 6, 16.

⁵³ *See id.* art. 134, at 61-62.

⁵⁴ *See, e.g., id.* recital 60, at 6; arts. 100-127, at 51-59.

⁵⁵ *See id.* art. 100, at 51.

⁵⁶ *See id.* recital 62, at 7.

⁵⁷ *See id.* art. 101, at 51.

⁵⁸ *See id.* art. 102, at 51-52.

Pursuant to the Framework Directive, an undertaking may calculate the SCR either pursuant to a new “standard” formula or using a full or partial internal model, both as discussed below.⁵⁹

i. “Standard” formula.

The Framework Directive provides for a “standard” formula for the calculation of the SCR,⁶⁰ taking into consideration various specified “modules” of risk (e.g., non-life / life / health underwriting risk, market risk, counterparty default risk).⁶¹ In this way, the standard formula is calculated on a “modular” basis, such that exposure to each category is evaluated as an initial step and then subsequently aggregated.⁶² In this regard and pursuant to this standard formula, each of the aforementioned risk modules is to be calculated using a Value-at-Risk⁶³ measure such that an undertaking must operate with a confidence level of 99.5 % over a one-year period.⁶⁴

⁵⁹ See Framework Directive, *supra* note 3, art 100..

⁶⁰ See *id.* arts. 103-108, at 52-54. In accordance with the standard formula, the SCR is calculated as the sum of the Basic Solvency Capital Requirement (as described in Article 104 of the Framework Directive), the capital requirement for operation risk (as described in Article 107 of the Framework Directive) and the adjustment for the loss-absorbing capacity of technical provisions and deferred taxes (as described in Article 108 of the Framework Directive). *Id.*

⁶¹ See *id.* art. 104(1), at 52.

⁶² See *id.* recital ¶ 65, at 7.

⁶³ Value-at-Risk (VaR) is a measure used to assess risk associated with a portfolio of assets and liabilities. Specifically, Value-at-Risk provides a measure of the “worst expected loss under normal conditions over a specific time interval at a given confidence level.” See FAQs, *supra* note 8, at 4.

⁶⁴ See Framework Directive, *supra* note 3, art. 101(4), at 51.

[T]he Solvency Capital Requirement should be determined as the economic capital to be held by insurance and reinsurance undertakings in order to ensure that ruin occurs no more often than once in every 200 cases or, alternatively, that those undertakings will still be in a position, with a probability of at least 99.5 %, to meet their obligations to policyholders and beneficiaries over the following 12 months. That economic capital should be calculated on the basis of the true risk profile of those undertakings, taking account of the impact of possible risk mitigation techniques, as well as diversification effects.

As indicated above, Solvency II will introduce the requirement that undertakings hold capital against market risk, that is to say investment-related risk.⁶⁵ Such a requirement is designed to mitigate possible procyclical effects of the financial markets and the negative effects suffered by an undertaking as a result thereof.⁶⁶ Therefore, as concerns the market risk module, undertakings will necessarily need to evaluate the appropriateness and risks inherent in any particular investment strategy.⁶⁷

One of the principle ways in which the design and potential impact of the standard model, among other factors (e.g., own funds, valuation of assets / liabilities), continues to be tested is through quantitative impact studies (QIS).⁶⁸ Such studies consist of simulations conducted by undertakings on a voluntary basis, with the next study (QIS 5) scheduled for 2010.⁶⁹

ii. Full or Partial Internal Model.

As an innovative and forward-looking alternative -- one that is generally applicable across undertakings and insurance products -- Solvency II provides that any insurance undertaking may decide whether to calculate SCR using full or partial internal modeling.⁷⁰ Such models are subject to the prior approval of the applicable supervisory authorities.⁷¹ In any application for approval,⁷² undertakings must, among other things, demonstrate that any internal model is widely used in and plays a significant role in the undertaking's internal risk management and decision-making processes ("use test").⁷³ An undertaking's management is responsible on an on-going basis for ensuring that any particular internal model continues to operate appropriately.⁷⁴ In addition, such partial

See id. at 7. Provisions specific to the calculation of the standard solvency requirement are set forth in the Framework Directive at art. 105. *See id.* recital ¶ 64, at 7. *See id.* art. 105, at 52-53.

⁶⁵ *See, e.g., id.* art. 100, at 51.

⁶⁶ *See id.* recital ¶ 61, at 6-7.

⁶⁷ *See* FAQs, *supra* note 8, at 6.

⁶⁸ *See, e.g.,* Comm. of European Ins. & Occupational Pensions Supervisors, *Consultations*, <http://www.ceiops.eu/content/view/3/3/> (last visited Mar. 23, 2010).

⁶⁹ *See id.*

⁷⁰ *See* Framework Directive, *supra* note 3, art. 112-27, at 56-59.

⁷¹ *See id.* art. 113, at 56.

⁷² *Id.* Art. 112(3), at 56.

⁷³ *See id.* Art. 120, at 57.

⁷⁴ *See id.* Art. 116, at 57.

internal modeling may be applied to the insurance business as a whole or to one or more specific business units.⁷⁵

b. *Minimum Capital Requirement (MCR).*

Pursuant to the Framework Directive, Member States must require that insurance undertakings hold eligible basic funds (as discussed further below) to cover the Minimum Capital Requirement (MCR).⁷⁶ The MCR represents a minimum solvency floor below which policyholders and beneficiaries are exposed to an unacceptable level of risk if undertakings were allowed to continue operating.⁷⁷ A breach of the MCR exposes the applicable undertaking to serious supervisory actions, as discussed further below.

The MCR is calculated as a linear function of various variables (net of reinsurance), including technical provisions, written premiums, capital-at-risk, deferred tax and administrative expenses.⁷⁸

The MCR is based on an 85% “confidence level” over the subsequent one-year period.⁷⁹ Furthermore, the Framework Directive provides that the MCR shall not fall below 25%, nor exceed 45%, of the undertaking’s SCR.⁸⁰ In addition, the MCR shall be subject to an absolute floor. For example, subject to limited exceptions, an absolute capital floor of € 2,200,000 applies to non-life insurance undertakings.⁸¹

Undertakings are required to calculate the MCR on a quarterly basis, at a minimum, and report related results to the applicable authorities.⁸² Further details in respect of the calculation of both the MCR and SCR (including as concerns internal modeling) will be the subject of implementing measures to be adopted by the European Commission.⁸³

⁷⁵ See *id.* Art. 112(2), at 56.

⁷⁶ Framework Directive, *supra* note 3, art. 129(4), at 60.

⁷⁷ See *id.* Art. 129(5), at 60.

⁷⁸ See *id.* art. 129(2), at 60.

⁷⁹ See *id.* art. 129(1), at 59-60.

⁸⁰ See *id.* art. 129(3), at 60.

⁸¹ See *id.* art. 129(1), at 59-60.

⁸² Framework Directive, *supra* note 3, art. 129(4), at 59-60.

⁸³ See *id.* art. 129(1), at 59-60.

3. U.S. System Applicable to Capital Controls; Risk-based Capital (RBC) System

In the U.S., undertakings are subject to a Risk-based Capital (RBC) system, a capital adequacy standard model designed by the National Association of Insurance Commissioners (NAIC).⁸⁴ An individual factor-based RBC model exists for each primary insurance type (life, property/casualty, health), and each generic formula focuses on certain risks that are common to the particular insurance type, rather than all risks to which a particular undertaking is exposed.⁸⁵ This capital adequacy measure is supplemented by various additional state specific capital-related requirements, including minimum capital requirements which vary among states.⁸⁶

Unlike the SCR and MCR under Solvency II which, among other things, are based on overall confidence/target levels discussed above, RBC is based on the principle that each particular risk faced by an undertaking is to be assigned an equity capital.⁸⁷ Unlike the Solvency II regime as discussed above, operational and catastrophic risk are not explicitly taken into consideration as part of U.S. RBC standards.⁸⁸ Moreover, U.S. RBC standards do not apply to reinsurers, which are subject to various state-based requirements, while as a general matter, reinsurers fall within the scope of Solvency II.⁸⁹ U.S. RBC standards employ a covariance formula in respect of determining capital requirements,⁹⁰ a basis which does not reflect the approach adopted by Solvency II to account for the interaction of such factors such as assets and liabilities and risk mitigation and diversification.⁹¹

One of the most significant differences between Solvency II and the current U.S. RBC system is the approach taken to internal models.

⁸⁴ NAIC, *Risk-based Capital General Overview*, July 15, 2009, available at http://www.naic.org/documents/committees_e_caped_RBCoverview.pdf [hereinafter *Risk-based Capital General Overview*]; Martin Eling & Ines Holzmüller, *An Overview and Comparison of Risk-based Capital Standards 2* (June 2008) (unpublished working paper, on file with the University of St. Gallen Institute of Insurance Economics).

⁸⁵ Eling & Holzmüller, *supra* note 84, at 4-5.

⁸⁶ *Id.* at 3.

⁸⁷ *Id.* at 4.

⁸⁸ *Id.* at 15.

⁸⁹ *Id.* at 20-21.

⁹⁰ *Risk-based Capital General Overview*, *supra* note 84, at 2; Eling & Holzmüller, *supra* note 84, at 20-21.

⁹¹ Eling & Holzmüller, *supra* note 84, at 20-21.

Contrary to the approach as discussed above under Solvency II which introduces the option of internal models across the collective insurance industry, the use of internal modeling in the U.S. remains relatively limited.⁹² Partial internal modeling is applied in the U.S., on an incremental basis, in respect of certain products, subject to various safeguards.⁹³ In this regard, for example, while certain undertakings may calculate required capital and reserves using internal models, such undertakings are nevertheless required to also calculate such items pursuant to a standard formula prescribed by the regulators, effectively providing for an explicit floor in respect of reserves and required capital.⁹⁴

In addition, as described above, the use of internal models under the Solvency II system is subject to the prior review and approval of the applicable supervisors. In contrast, rather than conducting their own review and approval of internal models, U.S. supervisors tend to rely on the analysis conducted by the particular undertaking's actuaries in respect of a model's appropriateness and results.⁹⁵

In 2008, the National Association of Insurance Commissioners announced a Solvency Modernization Initiative (SMI), which examines international developments (e.g., Solvency II) and their potential applicability to U.S. regulation.⁹⁶ An important focus of SMI concerns the review of the use of internal models, including the application of internal models to a wider range of insurance products.⁹⁷ By way of specific example, consideration is being given to the possible use of full internal modeling by an undertaking, subject to certain safeguards (e.g., prior approval) as a replacement for RBC.⁹⁸

⁹² Therese M. Vaughan, *The Implications of Solvency II for U.S. Insurance Regulation*, Networks Financial Institute at Indiana State University, Feb. 2009, at 11, available at http://www.insurance.naic.org/Releases/2009_docs/090305_vaughan_presentation.pdf [hereinafter *Implications of Solvency II for U.S. Insurance Regulation*].

⁹³ *Id.*

⁹⁴ *Id.* at 8, 11.

⁹⁵ *Id.* at 11.

⁹⁶ See Ramon M. Calderon, Dir., NAIC Ctr. For Ins. Policy & Research, Presentation at the NAIC Casualty Actuarial Society Annual Meeting (Nov. 16, 2009),. See NAIC, *NAIC Solvency Modernization Initiative*, available at http://www.naic.org/documents/committees_ex_isftf_smi_overview.pdf [hereinafter SMI].

⁹⁷ See *id.*

⁹⁸ See *id.*

4. Compliance with the SCR / MCR: Enforcement Actions

Pursuant to the Framework Directive, insurance undertakings must have procedures in place to identify an undertaking's deteriorating financial condition and in the event of such deterioration, undertakings must "immediately" notify the applicable supervisors.⁹⁹ As discussed below, the level of supervisory intervention and the specific mechanisms employed by regulators will progressively intensify with the degree of erosion of the undertaking's financial health.¹⁰⁰

As specifically concerns the SCR, within two months from an undertaking observing non-compliance with this capital requirement, the undertaking must submit a "realistic recovery plan" to the applicable supervisors for approval.¹⁰¹ Within six months from the observation of such non-compliance, the undertaking must re-establish the level of its eligible own funds to cover the SCR or reduce the undertaking's risk profile to ensure compliance with the SCR.¹⁰² Supervisors may, "if appropriate," extend this period by an additional three months.¹⁰³ Moreover, the applicable supervisor may grant yet another extension in the event of an exceptional deterioration in the financial markets (the specific factors to be considered by supervisors in granting this addition extension are to be set forth in implementing measures adopted by the European Commission).¹⁰⁴ If the applicable supervisor should determine that the financial situation of an undertaking will continue to deteriorate, such supervisors may, under exceptional circumstances, restrict such undertaking's ability to dispose of its assets.¹⁰⁵

⁹⁹ See Framework Directive, *supra* note 3, art 136, at 62.

¹⁰⁰ *Id.* arts. 136-39, at 62-63.

¹⁰¹ See *id.* art. 138(2), at 62. Such recovery plan must address certain specific matters as set forth in the Framework Directive (e.g., estimates of management expenses, income and expenditures). See *id.* art. 142, at 63.

¹⁰² See *id.* art. 138(2), at 62.

¹⁰³ *Id.*

¹⁰⁴ See Framework Directive, *supra* note 3, art. 138(4), at 62-64; art. 143, at 64. By way of example, one of the high level issues identified by CEIOPS and Commission Services for review in respect of Pillar II measures includes the determination of the maximum period of time which supervisory authorities can extend to undertakings in the event of exception market falls. See CEIOPS Policy Issues and Options, *supra* note 31.

¹⁰⁵ See Framework Directive, *supra* note 3, art. 138(5), at 63. In this regard, Member States are to take the steps required to restrict the free disposal of assets

Non-compliance by an undertaking with the MCR is subject to separate remedial provisions under the Framework Directive.¹⁰⁶ Within one month from the observation by an undertaking of non-compliance with the MCR, such undertaking must provide to the applicable supervisors a “realistic financial scheme.” Such plan is designed to restore, within a period of three months from the observation of non-compliance, the eligible basic own funds to at least the level of the MCR or to reduce its risk profile accordingly.¹⁰⁷ As is the case with the SCR, the applicable supervisors may place restrictions on an undertaking’s ability to dispose of its assets in light of continuing financial difficulties.¹⁰⁸ Importantly, the applicable supervisor shall withdraw the authorization granted to an undertaking to engage in insurance business in the event that an undertaking fails to comply with the MCR and the supervisors determine that the submitted finance scheme is “manifestly inadequate” or the undertaking fails to comply with such scheme within the applicable period.¹⁰⁹

In addition to those measures described above, the supervisory authorities shall have the power, subject to a principle of proportionality, to take “all measures necessary” to safeguard the interests of policyholders.¹¹⁰

5. Own Funds

As concerns an undertaking’s capital resources, the SCR and MCR must be covered by eligible “own funds” (e.g., regulatory capital) which are divided between “basic own funds” and “ancillary own funds.”¹¹¹ In this regard, basic own funds include subordinated liabilities and the excess of assets over liabilities,¹¹² and ancillary own funds include other items which may be called on to absorb losses (e.g., letters of credit, guarantees, other “legally binding commitments”, unpaid share capital).¹¹³

located in their territory at the request of the applicable undertaking’s home Member State which shall specify what assets are concerned. *Id.*

¹⁰⁶ See *id.* arts. 139-42, at 63.

¹⁰⁷ See *id.* art. 139(2), at 62. Such finance scheme must address certain specific matters as set forth in the Framework Directive (e.g., estimates of management expenses, income and expenditures). See *id.* art. 142, at 63.

¹⁰⁸ See *id.* art. 139(3), at 63.

¹⁰⁹ See Framework Directive, *supra* note 3, art. 144(1), at 64.

¹¹⁰ See *id.* art. 141, at 63.

¹¹¹ See *id.* art. 87-90, at 48.

¹¹² See *id.* art. 88, at 48.

¹¹³ See *id.* art. 89, at 48.

Furthermore, ancillary own funds are subject to approval by the applicable supervisors, for example, as concerns either the specific monetary value to be ascribed to such item or the method to be applied in determining such value.¹¹⁴

Pursuant to the Framework Directive, own funds are classified in accordance with a three tier system, based in part on an item's degree of liquidity, permanence and loss-absorbing capacity.¹¹⁵ Furthermore, the Framework Directive prescribes the specific amount of an undertaking's own funds which may fall within each of the prescribed tiers.¹¹⁶ By way of example, the proportion of Tier 1 items (high quality capital) must be greater than 1/3 of the total amount of an undertaking's eligible own funds covering the SCR.¹¹⁷

As compared with other provisions of the Framework Directive, the provisions relating to eligible own funds are relatively broad and high level, and the related requirements are subject to clarification and development through additional implementing measures.¹¹⁸

By way of comparison concerning the quality of capital resources, for example, U.S. RBS standards do not follow this tiered approach to available capital, but instead provide for a single overall amount of available capital.¹¹⁹ Furthermore, rather than taking into consideration account off-balance-sheet items (e.g., letters of credit) in the calculation of an undertaking's available capital, such items are instead taken into consideration in the calculation of an undertaking's required capital under the U.S. RBS standards.¹²⁰

¹¹⁴ See *id.* art. 90, at 48.

¹¹⁵ See Framework Directive, *supra* note 3, art. 93, at 49.

¹¹⁶ See *id.* art. 98, at 50.

¹¹⁷ *Id.*

¹¹⁸ See *id.* Art. 97, at 50.

¹¹⁹ See *Risk-based Capital General Overview*, *supra* note 84, at 3-4. The National Association of Insurance Commissioners appears to be moving in the general direction of a tiered approach, at least as concerns the amount of collateral security that will be required of reinsurers, see NAT'L ASSOC. INS. COMM'RS, REINSURANCE REGULATORY MODERNIZATION ACT OF 2009, available at http://www.naic.org/documents/committees_e_reinsurance_090915_reins_ref_modernization_act.pdf.

¹²⁰ *Id.*

6. Valuation of Assets / Liabilities

For supervisory purposes and to limit the administrative burden on undertakings, under the Framework Directive, valuation standards are to be compatible, to the extent possible, with international accounting developments.¹²¹ More specifically, the Framework Directive provides that assets and liabilities shall be valued consistent with an amount determined on an arm's length basis.¹²² Particular methods and assumptions to be used in the valuation of assets and liabilities will be set forth in future implementing measures from the European Commission.¹²³

By way of quick comparison, no single valuation methodology applies across the U.S., as states apply varying approaches to valuation including, for example, book value, market value, and amortized costs.¹²⁴

7. Permitted Investments

As concerns investments, undertakings will enjoy increased flexibility as concerns the scope of their investment decisions under the Solvency II regime, provided that investments are made in compliance with the so-called "prudent person principle" as set forth in the Framework Directive.¹²⁵ Pursuant to this principle, undertakings will only be permitted to invest in assets and instruments which the undertaking may, for example, properly identify, measure, control and monitor and take into account in the undertaking's assessment of its overall solvency requirements.¹²⁶ Furthermore, assets are to be invested by undertakings such as to ensure the "security, quality, liquidity and profitability of the portfolio as a whole."¹²⁷

In this regard, Member States will not be able to require that undertakings invest in any particular category of asset or subject

¹²¹ See Framework Directive, *supra* note 3, recital ¶ 46, at 5.

¹²² See *id.* art. 75, at 45; the main principles applicable to the valuations of assets are consistent, as a general matter, with the definition of fair value under IFRS. See CEIOPS' *Advice for Level 2 Implementing Measures on Solvency II: Valuation of Assets and "Other Liabilities,"* at 3, October 2009, CEIOPS-DOC-31/09. [hereinafter CEIOPS Level 2 Advice: Valuation of Assets and "Other Liabilities"].

¹²³ See Framework Directive, *supra* note 3, art. 74, at 45; see also CEIOPS Level 2 Advice: Valuation of Assets and "Other Liabilities," *supra* note 122.

¹²⁴ See e.g., Risk-Based Capital Standards, *supra* note 84.

¹²⁵ See Framework Directive, *supra* note 3, art. 132, at 60.

¹²⁶ See *id.* art. 132(2), at 61.

¹²⁷ See *id.*

investment decisions to notification or approval requirements.¹²⁸ However, for example, in order to ensure the uniform application of applicable provisions of Solvency II, the European Commission may adopt implementing measures providing for qualitative requirements (e.g., monitoring, managing and reporting of risks) in respect of certain investments.¹²⁹

By way of comparison, U.S. rules applicable to permitted investments vary from state to state and tend to be based on a combination of the prudent person principle and a rules-based approach.¹³⁰

B. PILLAR II: GOVERNANCE AND RISK MANAGEMENT REQUIREMENTS.

As succinctly observed by Thomas Steffen, Chairman of CEIOPS in his presentation of the Framework Directive, "... Solvency II is not just about capital. It is a change of behavior—for the sake of enhanced consumer protection, financial stability and efficiency of insurance markets."¹³¹

One of the ways in which this change in behavior will be brought about, and heading lessons learned from the financial crisis, is through the provisions of the Framework Directive applicable to enhanced governance and risk management.¹³² In this way, governance requirements are able to address certain risks which are not properly dealt with through the quantitative requirements as set forth in Pillar I as discussed above.¹³³ In this regard, the Framework Directive requires insurance undertakings to implement effective risk management systems, allowing undertakings to identify, measure, manage and report risks.¹³⁴ Such systems must provide for the "sound and prudent management of the business" and, among other

¹²⁸ See *id.* art. 133, at 61.

¹²⁹ See *id.* art. 135, at 62.

¹³⁰ See Implications of Solvency II for U.S. Insurance Regulation, *supra* note 92, at 12. The State of New York announced an intent to move toward a principles-based system in respect of regulating reinsurers, *see e.g.*, <http://www.ins.state.ny.us/press/2007/p0710181.htm>.

¹³¹ See Steffen Presentation, *supra* note 9.

¹³² Studies concerning actual and near failures of undertakings as conducted by CEIPOS indicate that the "primary causes of failures were poor management and inappropriate risk decisions rather than inadequate capitalisation per se." See FAQs, *supra* note 8, at 5.

¹³³ See Framework Directive, *supra* note 3, recital ¶ 29, at 4.

¹³⁴ See *id.* art. 44, at 34.

things, include an adequate transparent organizational structure, be subject to written policies and regular internal review.¹³⁵ As concerns the scope of such risk management systems, they must cover such matters as the risks included in the prescribed SCR calculation, underwriting and reserving, asset / liability management, investments and liquidity and concentration risk management.¹³⁶ Furthermore, such systems are required to be well integrated into the particular organizational structure as well as the decision making processes of the undertaking.¹³⁷

Importantly, the Framework Directive places ultimate responsibility with an undertaking's management or administration as concerns the undertaking's compliance with the various measures adopted in respect of the Framework Directive, including the implementation of the required risk management system.¹³⁸ Moreover, the Framework Directive sets forth requirements as concerns those persons who may run the undertaking or have other key functions.¹³⁹ In this regard, such individuals must be of "good repute and integrity" and have adequate professional qualifications, knowledge and experience as concerns the effective management of the undertaking.¹⁴⁰

As part of its overall risk management framework, each undertaking will be required to implement an internal control system, including the establishing of risk-related "functions" or specific areas of expertise and responsibility.¹⁴¹ Such functions include a compliance function that serves to advise management on applicable compliance matters, including in respect of the identification and assessment of compliance risk,¹⁴² an internal audit function (e.g., responsibilities include the evaluation of the adequacy and effectiveness of the internal control and governance system)¹⁴³ and an actuarial function (e.g., undertaking the coordination of the calculation of technical provisions, ensuring the appropriateness of the methodologies and models used by the undertaking,

¹³⁵ See *id.* art. 41, at 33.

¹³⁶ See *id.* art. 44, at 34.

¹³⁷ See *id.*

¹³⁸ See *id.* art. 40, at 33.

¹³⁹ See Framework Directive, *supra* note 3, art. 42, at 33. Matters related to proof of good repute, and the recognition of same by Member States, are addressed in Article 43 of the proposed Framework Directive, *supra* note 3.

¹⁴⁰ See *id.*

¹⁴¹ See *id.* art. 46, at 35.

¹⁴² See *id.*

¹⁴³ See *id.* art. 47, at 35.

expressing an opinion as to the overall underwriting policy and adequacy of reinsurance arrangements).¹⁴⁴

As a general matter, an undertaking may outsource the foregoing functions, among others. However, the outsourcing of critical or important operational functions or activities¹⁴⁵ is subject to certain enumerated conditions. For example, such outsourcing may not materially impair the quality of the undertaking's governance system or unduly increase operational risk.¹⁴⁶ In order to ensure effective supervision of outsourced functions or activities, supervisors are to have access to relevant data held by the outsourcing provider as well as have the right to perform on-site inspections.¹⁴⁷ In any event, Member States are to ensure that in the event that an undertaking chooses to outsource particular functions or activities, such undertakings are to remain fully responsible for discharging their obligations under the Framework Directive.¹⁴⁸

1. Own Risk and Solvency Assessment (ORSA)

As a critical part of an undertaking's risk management system, each undertaking will be required to regularly undertake a so-called "own risk and solvency assessment (ORSA)."¹⁴⁹ In this regard, an undertaking must assess the short and long term risks which it may face, or be

¹⁴⁴ See *id.* art. 48, at 36. The requirement as to an actuarial function is controversial considering that this requirement is not provided for in Solvency I and will apply to both non-life and life undertakings. As an example regarding the on-going consultations with CEIOP in respect of the contemplated actuarial function, the actuarial trade association Group Consultatif Actuariel Européen has proposed various specific technical and public interests standards to be applicable in this area (e.g., public interest standards should encompass actuarial, ethical, governance and communications standards). See Groupe Consultatif Actuariel Européen, *Professional Standards for the Actuarial Function under Solvency II* (Sept. 29, 2009), available at <http://www.gcactuaries.org/documents>.

¹⁴⁵ The functions included within the governance system are considered to be "key functions and consequently also important and critical functions." See Framework Directive, *supra* note 3, recital ¶ 33, at 4.

¹⁴⁶ See *id.* art. 49, at 36.

¹⁴⁷ See *id.* recital ¶ 37, at 4, art. 38, at 32.

¹⁴⁸ See *id.* art. 49, at 36.

¹⁴⁹ See *id.* art. 45, at 34. In this regard, CEIOPS interprets "regularly" to mean at least annually. See CEIOPS, *Issues Paper: Own Risk and Solvency Assessment (ORSA)* ¶ 49, at 12 (May 27, 2008), available at http://www.ceiops.eu/media/docman/public_files/consultations/IssuesPaperORSA.pdf [hereinafter CEIOPS: ORSA Issues Paper].

anticipated to face, and determine the own funds necessary to meet the undertaking's solvency needs on an on-going basis.¹⁵⁰ In this way, Solvency II aims to integrate risk and capital management, necessarily promoting and implicating effective and forward-looking risk management as a principal consideration throughout the governance and decision making process of an undertaking.¹⁵¹

The ORSA does not require the development of a specific internal model or the calculation of capital requirements in addition to the SCR and MCR.¹⁵² The choice as to the particular ORSA process adopted is left to the discretion of the particular undertaking, however, the process must meet prescribed guidelines.¹⁵³ The results and information concerning the particular process undertaken in respect of the ORSA must be reported by an undertaking to the applicable supervisory authorities, thereby providing supervisors with the means for evaluating the risk profiles of undertakings.¹⁵⁴

While the Framework Directive addresses the principal requirements and matters to be addressed in the ORSA, certain undertakings have argued that the Framework Directive does not provide sufficient detail regarding the specific results which are to be achieved. As a result, there is some uncertainty in the market, particularly on the part of smaller undertakings worried that the requirements under the ORSA may be overly complex and burdensome.¹⁵⁵ Although the ORSA will likely be subject to Level 3 guidance from CEIOPS, it is not expected that there will be Level 2 implementing measures in respect of the ORSA.¹⁵⁶ Therefore, in an effort to address the calls of the market for guidance in this area, CEIOPS has launched discussions regarding the scope and goals of the ORSA and has offered preliminary guidance in this regard.¹⁵⁷ By way of example, CEIOPS has enumerated various principles which undertakings should observe in conducting the ORSA (e.g., the ORSA should be regularly reviewed and approved by the undertaking's administrative or

¹⁵⁰ See Framework Directive, *supra* note 3, art. 45, at 35; see CEIOPS: ORSA Issues Paper, *supra* note 149, ¶ 9, at 5.

¹⁵¹ See e.g., Framework Directive, *supra* note 3, art. 45, at 35.

¹⁵² See *id.* recital ¶ 36, at 4.

¹⁵³ See *id.* art. 45, at 34-35.

¹⁵⁴ See *id.*

¹⁵⁵ See CEIOPS: ORSA Issues Paper, *supra* note 149, ¶¶ 2-3, at 4.

¹⁵⁶ See *id.* ¶ 5, at 4-5.

¹⁵⁷ See *id.* ¶ 6, at 5.

management body; the ORSA process and results should be appropriately evidenced, internally documented and independently assessed).¹⁵⁸

This approach to enterprise risk management under Solvency II marks one of the most significant differences from the current U.S. system. In the U.S., such evaluation is not part of the RBC system, and undertakings are not otherwise required to implement risk management systems such as that provided under the ORSA.¹⁵⁹ In this regard, while undertakings in the U.S. are required to analyze the risks that they face by virtue the U.S. regulatory regime (e.g., risk-based capital requirements),¹⁶⁰ there is no requirement for these undertakings to prepare specific internal risk assessment-related documentation and then provide such materials to the applicable supervisors.¹⁶¹ It should be noted that the introduction of enterprise risk management requirements are being considered as part of the NAIC's Solvency Modernization Initiative.¹⁶²

2. Group Supervision

Under the Framework Directive, Member States will be required to provide for group-level supervision of insurance undertakings.¹⁶³ Significantly, Solvency II streamlines the group supervision process by providing that group insurance undertakings are to be supervised through a single "group supervisor" in the group's home Member State, the duties of whom would necessarily be exercised in cooperation with the relevant

¹⁵⁸ See CEIOPS: ORSA Issues Paper, *supra* note 149, ¶ 55, at 13.

¹⁵⁹ See SMI, *supra* note 96.

¹⁶⁰ See Solvency Modernization Initiative (EX) Task Force, *Issues for Consideration in the Solvency Modernization Initiative 3* (June 14, 2009), available at http://www.naic.org/documents/committees_ex_isftf_090615_04_solvency_issues.pdf.

¹⁶¹ See Letter from Mike Moriart, Chair, Risk Assessment Working Group (E), *Risk-Focused Examination Approach* (Jan. 18, 2007) (on file with NAIC, available at http://www.naic.org/documents/committees_e_examover_fehtg_letter__risk_focused_exams.pdf).

¹⁶² See SMI, *supra* note 96. An enhanced risk-focused examination approach will be required to be applied by U.S. regulators in 2010, and the NAIC expects that similar information to that provided by the ORSA will be collected by this revised risk-focused examination approach. See Implications of Solvency II for U.S. Insurance Regulation, *supra* note 92, at 9.

¹⁶³ See Framework Directive, *supra* note 3, arts. 212-266, at 81-102.

national supervisors.¹⁶⁴ Such group supervisor will have primary responsibility for the group's supervision and chair a college of supervisors made up of representatives from Member States where the group has operations.¹⁶⁵ This model marks a break from the existing system, argued to be overly burdensome on larger group undertakings, which provides for supervision on the group and sub-group level and which fails to define with sufficient clarity the roles and duties of the various supervisory authorities in this regard.¹⁶⁶

These revised regulations as to group supervision will allow insurance groups to operate more efficiently and result in a reduction of related costs. In addition, the new group supervision rules are designed to foster cooperation among supervisory authorities as well as improve assessments of the overall financial situation of group undertakings.¹⁶⁷ Moreover, under Solvency II, insurance groups will be able to avail themselves of group-wide models and take advantage of certain group diversification benefits.¹⁶⁸

It is important to point out that the Framework Directive does not contain the "group support" language as proposed in earlier drafts of the Framework Directive (Title III).¹⁶⁹ As a result, under the contemplated regime, a particular insurance undertaking will not be permitted to use capital held elsewhere in the group in order to calculate the undertaking's SCR, regardless of the group's capital as a whole.¹⁷⁰ However, the European Commission has indicated that it may revisit the issue of group

¹⁶⁴ See *id.* arts. 247-251, at 95-98.

¹⁶⁵ See *id.* art. 248, at 97.

¹⁶⁶ See Council Directive 98/78, 1998 O.J. (L 330) 1-12 (EC), available at <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:1998:330:0001:0012:EN:PDF>.

¹⁶⁷ See Framework Directive, *supra* note 3, arts. 247-251, at 95-98; FAQs, *supra* note 8, at 10.

¹⁶⁸ See Framework Directive, *supra* note 3, arts. 212-266, at 81-102; CEIOPS, *CEIOPS' Advice for Level 2 Implementing Measures on Solvency II: Assessment of Group Solvency* (OCT. 2009), available at <http://www.ceiops.eu/media/files/consultations/consultationpapers/CP60/CEIOPS-L2-Final-Advice-Group-solvency-assessment.pdf>.

¹⁶⁹ See FAQs, *supra* note 8, at 11.

¹⁷⁰ Press Release, European Commission, "Solvency II": European Parliament Approval of Proposed Directive Brings Modern Insurance Regulation Nearer, (Apr. 22, 2009) (available at <http://europa.eu/rapid/pressReleasesAction.do?reference=IP/09/621&format=HTML&aged=0&language=EN&guiLanguage=en>.)

support once progress has been made in other various identified areas related to insurance regulation.¹⁷¹

C. PILLAR III: TRANSPARENCY AND MARKET DISCIPLINE.

1. Reporting.

The Framework Directive calls for consistent supervisory reporting and disclosure across the EU, strengthening transparency and overall market discipline.¹⁷²

Specific details concerning the reporting requirements, which go beyond those currently required to be disclosed under the current regulatory regime, are to be developed through future implementing measures (e.g., as to content, form, modalities).¹⁷³ However, the Framework Directive does provide certain high level guidance as concerns reporting.¹⁷⁴ For example, undertakings will be required to publicly disclose a report, on an annual basis, concerning their solvency and financial condition. This report is to include, for example, a description of the system of governance and an assessment of its adequacy, a description of the capital management including references to the structure and amount of own funds and their quality, the amounts of the SCR and MCR and the underlying assumptions, and any non-compliance with the foregoing.¹⁷⁵ An undertaking may, on a voluntary basis, supplement the basic disclosure with additional information concerning the undertaking's solvency or financial condition.¹⁷⁶ As a practical matter, such Pillar III reporting will likely draw upon information gathered in respect of Pillar I and the ORSA of Pillar II.¹⁷⁷ While certainly presenting challenges in seeking a balance between proprietary and public information, such public disclosure is seen as essential in strengthening market discipline by improving the

¹⁷¹ See Framework Directive, *supra* note 3, recital ¶ 141, at 13.

¹⁷² See *id.* art. 51, at 36.

¹⁷³ See *id.* art. 56, at 38. By way of example, certain high level issues identified by CEIOPS and Commission Services as being of particular importance for review in respect of public disclosure concern the compatibility with other reporting rules and the introduction of proportionate requirements for small undertakings. See also CEIOPS Policy Issues and Options, *supra* note 31.

¹⁷⁴ See Framework Directive, *supra* note 3, art. 51, at 36.

¹⁷⁵ See *id.* art. 51(1), at 37.

¹⁷⁶ See *id.* art. 54(2), at 38.

¹⁷⁷ See *id.* arts. 35, at 30; art. 45, at 34-35.

accountability of undertakings and providing increased information to policyholders and beneficiaries.

2. Supervision: Generally.

In addition to the points already discussed herein as concerns supervision, a few additional points specific to the general principles of supervision should be made here.¹⁷⁸

Under Solvency II, Member States are to ensure that supervisors are provided with the required “means, and have the relevant expertise and capacity, and mandate” to carry out the principal objective of supervision which is the protection of policyholders and beneficiaries.¹⁷⁹ Furthermore, taking into account the information available, supervisors are to give appropriate consideration to the potential impact of their decisions as concerns the stability of the larger EU financial systems.¹⁸⁰ In addition, the Framework Directive stresses that supervisors are to respect a principle of proportionality, as indicated above, in respect of the application of their powers.¹⁸¹

Supervision is to be based on a prospective risk-based basis, including on-going verification, and a mix of on-site inspections and off-site activities.¹⁸² In addition, supervisors are to carry out their duties in a “transparent and accountable” manner, with consideration to protecting confidential information.¹⁸³ Moreover, the Framework Directive provides for measures to facilitate the supervisory convergence and the flow of information among the various EU supervisory authorities.¹⁸⁴

It is important to point out that the financial supervision of insurance undertakings, including the business conducted by their branches or through the freedom to provide services, shall be the “sole”

¹⁷⁸ See Committee of European Insurance and Occupational Pensions Supervisors, *CEIOPS' Advice for Level 2 Implementing Measures on Solvency II: Supervisory Reporting and Public Disclosure Requirements*, (October 2009) (available at <http://www.solvencyii.ie/documents/CEIOPS-L2-Final-Advice-Own-funds-Criteria-supervisory-approval-of-AOF.pdf>).

¹⁷⁹ See Framework Directive, *supra* note 3, art. 27, at 28.

¹⁸⁰ See *id.* art. 28, at 28.

¹⁸¹ See *id.* art. 34(6), at 30.

¹⁸² See *id.* art. 29, at 28.

¹⁸³ See *id.* art. 31, at 29.

¹⁸⁴ See *id.* art. 64, at 41.

responsibility of a particular undertaking's home Member State.¹⁸⁵ In the event that the supervisors of a host Member State where an insurance risk is located have reason to consider that an undertaking's activities may impact its financial soundness, then such supervisors are to so inform the supervisors of such undertaking's home Member State.¹⁸⁶

3. Supervisory Review Process.

Another requirement introduced pursuant to the Framework Directive is the Supervisory Review Process (SRP), a specific process designed to improve the assessment of the ability of undertakings to withstand adverse changes in economic conditions.¹⁸⁷ As part of this overall process, Member States are required to ensure that applicable supervisors review and evaluate the "strategies, processes and reporting procedures" implemented by undertakings as part of their compliance efforts.¹⁸⁸ Specifically, supervisors are to review and evaluate compliance with such items as the system of governance (including the ORSA), and the technical provisions, capital requirements, investment rules, the quality and quantity of own funds, and requirements in respect of internal models, all as set forth in the Framework Directive.¹⁸⁹ Importantly, the Framework Directive provides that supervisors are to conduct such review and evaluations on a regular basis and that they should have the powers necessary to remedy identified weaknesses or deficiencies.¹⁹⁰

4. Capital Add-on.

As part of the supervisory review / enforcement process, the applicable supervisory authorities may in "exceptional"¹⁹¹ circumstances

¹⁸⁵ See Framework Directive, *supra* note 3, art. 30(1), at 28. Where an insurance undertaking authorized in another Member State conducts business in a host Member State through a branch office, then the supervisors of the undertaking's home Member State may conduct on-site verifications of the branch, provided that such supervisors have first notified the supervisors of the host Member State thereof. See *id.* art. 33, at 29.

¹⁸⁶ See *id.* art. 30(3), at 29.

¹⁸⁷ See *id.* art. 36, at 30.

¹⁸⁸ See *id.* art. 36(1), at 30-31.

¹⁸⁹ See *id.* art. 36(2), at 31.

¹⁹⁰ See Framework Directive, *supra* note 3, art. 36(4-6), at 31.

¹⁹¹ "The imposition of a capital add-on is exception in the sense that it should only be used as a last resort measure, when other supervisory measures are

require, with justification, undertakings to set aside additional capital.¹⁹² Such an add-on, which may be applied in respect of a particular undertaking or its group, will require the undertaking to maintain additional capital in excess of the SCR.¹⁹³ This capital add-on may be imposed when the applicable supervisory authority identifies, for example, a significant deviation from the applicable SCR or system of governance provided for pursuant to the Framework Directive.¹⁹⁴ The capital add-on should be maintained for such time as the circumstances under which it was imposed are not remedied.¹⁹⁵ Further implementing measures will be adopted by the European Commission in respect of the specific situations in which the capital add-on may be imposed by applicable supervisors, in addition to the particular methodologies to be employed in the calculation thereof.¹⁹⁶

VII. COLLATERAL REQUIREMENTS APPLICABLE TO REINSURERS

One of the most significant and continuing points of contention between U.S. and EU reinsurers and regulators is the application of collateral requirements to foreign reinsurers covering business in their jurisdiction. The primary concern behind such requirements is that such foreign reinsurers are not subject to the same local regulatory and judicial enforcement regime and, therefore, such undertakings present a heightened risk, and therefore should be required to pledge assets as a safeguard measure.¹⁹⁷

In this regard and as a general matter, U.S. regulators require foreign (e.g., EU) reinsurers which are not licensed or accredited in a U.S. state, and subject to various conditions, to post collateral in respect of their operations in the U.S.¹⁹⁸ In the EU, and as introduced through provisions of the EU Reinsurance Directive, Member States are prohibited from imposing collateral requirements on reinsurers from other Member

ineffective or inappropriate". *See id.*, recital ¶ 27, at 4; art. 37, at 31. *See also id.* art. 282, at 89 (regarding the group capital add-on).

¹⁹² *See id.* art. 37, at 31.

¹⁹³ *See id.*

¹⁹⁴ *See* Framework Directive, *supra* note 3, art. 37(1), at 31.

¹⁹⁵ *See id.* recital ¶ 28, at 4.

¹⁹⁶ *See id.* art. 37(6), at 32.

¹⁹⁷ *See* Gregory S. Arnold, *The Doubtful Impact of an Optional Federal Charter on the Reinsurance Collateral Debate*, 44 Tort Trial & Ins. Prac. L.J. 79 [hereinafter *Doubtful Impact of Optional Federal Charter*].

¹⁹⁸ *See id.* at 82. *See supra* notes 119, 130.

States.¹⁹⁹ However, Member States may choose to apply collateral requirements to non-EU reinsurers which provide reinsurance to undertakings regulated in Member States.²⁰⁰ By way of example, France allows for the imposition of such requirements in respect of non-EEA reinsurers.²⁰¹

As a move, in part, to assuage U.S. regulators, the Framework Directive contains language regarding the application of so so-called collateral requirements to non-EU reinsurers. Specifically, the Framework Directive prohibits EU Member States from requiring that a reinsurer pledge assets to cover unearned premiums and outstanding claims provisions if such reinsurer is an undertaking with its head office in a third country whose solvency regime is deemed to be “equivalent” pursuant to the Framework Directive.²⁰² The meaning of “equivalent” has yet to be defined or clarified, and more specifically, guidance has not been provided as to whether the U.S. solvency regimes would be deemed to be equivalent in this regard.

Many undertakings, insurance groups and regulators in both the U.S. and the EU continue to call for a reform of collateral requirements, arguing that such requirements are essentially outdated, discriminatory and anticompetitive. With moves like Solvency II, and particularly the collateral-related provisions discussed above, there may be reason for a certain degree of measured optimism that compromises might eventually be reached between EU and U.S. regulators in this regard.²⁰³

¹⁹⁹ Council Directive 2005/68, 2005 O.J. (L323) 16 (on reinsurance and amending Council Directives 73/239/EEC, 92/49/EEC as well as Directives 98/78/EC and 2002/83/EC, art. 32). As mentioned above in respect of the Framework Directive, it is important to point out that this Directive also has relevance to the larger European Economic Area, *supra* note 3.

²⁰⁰ See Framework Directive, *supra* note 3, art. 172, at 72.

²⁰¹ See *Code des Assurances*, C. Assur., art. R. 332-3-3 (French Insurance Code).

²⁰² See Framework Directive, *supra* note 3, art. 172, at 72. Furthermore, as concerns recoverables from reinsurance contracts against undertakings having their head office in a non-EEA country whose solvency system is deemed to be “equivalent” pursuant to the Framework Directive, Member States will be prohibited from requiring that assets representing such recoverables be located in the European Community, *id.* art. 134, at 61.

²⁰³ See, e.g., Doubtful Impact of Optional Federal Charter, *supra* note 197, at 106as concerns proposed reforms to collateral requirements from New York regulators.

VIII. ADDITIONAL MATTERS

As indicated in the introduction to this Article, the review herein is intended to provide, among other things, a survey of some of the principle regulatory changes introduced through Solvency II. However, it is important to briefly point out that the Framework Directive also recasts existing directives as indicated above, and as a result, addresses such other significant matters such as requirements concerning the taking-up, pursuit and prior authorization of undertakings wishing to engage in insurance activities,²⁰⁴ provisions in respect of the exchange of information among supervisory authorities and the promotion of supervisory convergence,²⁰⁵ duties of statutory auditors,²⁰⁶ and provisions specific to individual types of coverage²⁰⁷ and to the reorganization and winding-up of insurance undertakings.²⁰⁸

IX. KEY DIFFERENCES BETWEEN THE BASEL FRAMEWORK AND SOLVENCY II / ADDRESSING COMMON CONCERNS WITH SOLVENCY II BASED ON COMPARISONS TO BASEL II

As indicated above, Solvency II adopts the general three pillar approach of Basel II, the regulatory standard for financial institutions.²⁰⁹ However, it is important to understand the various significant differences between the two regimes, as well as bear in mind the key differences between the financial and insurance industries. Unfortunately, commentators are often far too quick to apply the banking experience into insurance. In this regard, the similarities between the Basel framework and Solvency II are frequently overstated, leading critics of Solvency II to argue that this initiative suffers from the same shortcomings of Basel II.

²⁰⁴ See Framework Directive, *supra* note 3, art. 14, at 24.

²⁰⁵ See *id.* art. 64, at 41.

²⁰⁶ See *id.* art. 72, at 43.

²⁰⁷ See *e.g.*, *id.* art. 206, at 79 (health insurance).

²⁰⁸ See *id.* art. 269, at 103.

²⁰⁹ See BIS Website, *supra* note 6.

A. KEY DIFFERENCES BETWEEN THE BASEL FRAMEWORK AND SOLVENCY II

Before addressing some of the most frequent concerns with Solvency II in this regard, it is important as an initial matter to address some of the key differences between the Basel framework and Solvency II.

1. Range of Risks Covered.

The range of risks included under Pillar I of Basel II is focused on operational risk, credit risk and market risk as concerns a financial institution's trading operations.²¹⁰ As described above, Solvency II aims to cover all quantifiable key risk areas. In this regard, Solvency II covers the same categories as Basel II, but also includes an expanded array of risks, including, by way of example, insurance risk, liquidity risk (an area of the Basel framework which is subject to continuing attention) as well as broader view of market risk across the entirety of an undertaking.²¹¹

2. Capital Requirements / Ladder of Supervisory Intervention.

Basel II provides for a single capital requirement.²¹² As described above, Solvency II provides for broader Pillar I provisions. In this regard, Solvency II provides for both a Solvency Capital Requirement (SCR) and a Minimum Capital Requirement (MCR). Once the SCR of an undertaking is breached, the intervention of supervisors is triggered in order to remedy the situation, and if the MCR is breached, increased supervisory measures are triggered, all as described above.²¹³ In this way, Solvency II provides for a graduated approach to supervisory intervention, a nuanced system which is not mirrored by Basel II's approach to capital adequacy.

3. Internal Modeling.

The approach to internal modeling under Basel II is limited to certain specific risk categories and specified applications (e.g., IRB framework for credit risks, AMA framework for operational risk). In

²¹⁰ See BIS Website, *supra* note 6, Pillar I.

²¹¹ See *infra* discussion of Pillar I provisions of Solvency II.

²¹² See BIS Website, *supra* note 6, Pillar I.

²¹³ See *supra* discussion of Pillar I provisions of Solvency II.

respect of credit risk, for example, companies are only permitted to use internal modeling to determine certain specific risk components.²¹⁴ In contrast, as described above, Solvency II provides that any undertaking subject to Solvency II may elect to use partial or full modeling, across categories, as an alternative to using the standard formula for calculating the SCR.²¹⁵

4. Diversification.

Under Basel II, diversification is addressed through a general assumption as to standard diversification which is then incorporated into the general calculation. As such, any company-specific diversification is particularly limited.²¹⁶ Solvency II, however, aims to make diversification specific to a particular undertaking and flexible enough to allow for group level matters.

5. Stakeholder Participation in the Initiative's Development.

The level of stakeholder participation in the development of each of Basel II and Solvency II is markedly different. Basel II was developed by a central committee (Basel Committee on Banking Supervision), with relatively limited stakeholder participation.²¹⁷ In contrast, as described above, Solvency II continues to be developed with the active involvement of the various stakeholders through such means as Quantitative Impact Studies (QIS).

B. COMMON CONCERNS WITH SOLVENCY II BASED ON COMPARISONS TO BASEL II

Against this background we can now address in brief a few common concerns with Solvency II based on comparisons to Basel II. In this regard, the author consulted with Mr. Karel van Hulle, Head of the Insurance and Pensions Unit of the European Commission responsible for

²¹⁴ See BIS Website, *supra* note 6, Pillar I.

²¹⁵ See *infra* discussion of Pillar I provisions of Solvency II.

²¹⁶ See BIS Website, *supra* note 6, Pillar I.

²¹⁷ See David Zaring, *Informal Procedure, Hard and Soft, In International Administration*, 5 *Chi. J. Int'l L.* 547, 555-61 (2005).

Solvency II (“Mr. van Hulle”), and his specific feedback is included herein.²¹⁸

1. Misinterpretation of the Objective of Solvency II— Capital Standards.

Frequently, commentators argue that Basel II effectively seeks to lower minimum capital requirements applicable to financial institutions. Therefore, in light of the financial crisis that has exposed many financial institutions as being undercapitalized, commentators question the advisability of implementing a system such as Solvency II which likewise seeks to relax capital standards in respect of insurance undertakings.

Such an argument is based on an inaccurate understanding of the objective of Solvency II. As emphasized by Mr. van Hulle, the objective of Solvency II is not to lower the capital requirements applicable to undertakings, but rather to express these capital requirements as part of a balanced and comprehensive reflection of the risks faced by any particular undertaking.²¹⁹ That being said, under the risk-based structure of Solvency II, lower capital requirements may indeed result for these undertakings which understand and manage their risks well. However, certain undertakings may face higher capital requirements under Solvency II since their capital may not have been risk-based, particularly affecting those undertakings which have managed their risks less adequately or have inadequate capital considering the amount of risk underwritten.

Furthermore, as concerns adjusting capital requirements and mindful of concerns as to the health of undertakings, Mr. van Hulle stresses that since there is no evidence that the EU insurance industry is undercapitalized, there would appear to be no reason for a general increase in requirements at this time.²²⁰

2. Use of Internal Modeling by Small and Medium Undertakings.

Under Solvency II, the use of internal modeling is available to be applied by any applicable insurance undertaking. Because of this, concerns have been raised as to whether small and medium undertakings will have,

²¹⁸ Interview with Karel van Hulle, Head of Unit, Ins. & Pensions Unit of the Eur. Comm’n, in PLACE (Jan. 12, 2010).

²¹⁹ *Id.*

²²⁰ *Id.*

in reality, the competence to conduct such modeling. In this regard, comparisons are drawn to the Basel II system, which as applied in the U.S., only permits internal modeling to be applied by a limited number of the largest financial institutions.

While a standard formula is limited in providing only an approximation, Mr. van Hulle stresses that as a general matter, a well-designed internal model strengthens a particular undertaking's focus on risk management and provides a more attuned alignment of such undertaking's specific capital and risk requirements.²²¹ While internal modeling is complex, it is expected that undertakings, regardless of their relative size, will be in a position to calculate the SCR on the basis of partial or full modeling.²²² In this regard, Mr. van Hulle points out that smaller undertakings often provide specialized and niche services who understand their particular risks very well, often even better than larger more diversified undertakings. Moreover, certain national supervisors are already actively working with undertakings, of varying sizes, in respect of the development of internal models, in anticipation of Solvency II coming into force in 2012. By way of example, the UK's Financial Services Authority (FSA) has created a dedicated Internal Model Approval Process (IMAP) team and continues to distribute various guidance in respect of internal modelling under Solvency II. In addition, the FSA has initiated a pilot program whereby four undertakings (of varying types and sizes) have been chosen to test the design of the IMAP. Furthermore, the FSA has launched plans to start a pre-application process in respect of internal models this year.²²³

3. Development of Internal Models.

In light of the financial crisis, concerns have been expressed as to whether internal modeling under Solvency II will be subject to the same shortcomings as seen as applies to financial institutions under Basel II. Specifically, will Solvency II ensure that internal models are actually used by undertakings to understand their risks, as opposed to such models being developed simply as a tool to be used by regulators?

²²¹ *Id.*

²²² *Id.*

²²³ See *Solvency 2 - IMAP Update Helping You Prepare*, Financial Services Authority Release (Oct. 2009), available at http://www.fsa.gov.uk/pubs/international/imap_update_oct.pdf.

In this regard and as an initial matter, Mr. van Hulle stresses that it is important to understand the differences between internal modelling as between financial institutions and insurance undertakings. Internal modelling in respect of financial institutions must necessarily take into account various factors which are difficult to predict (e.g., interest rates). On the other hand, Mr. van Hulle points out that factors in respect of internal modelling for insurance undertakings are often more discretely defined and relatively stable (e.g., longevity). As concerns underwriting risk, Mr. van Hulle remarks that internal modelling in insurance looks into the past and projects into the future.²²⁴ In this regard, he notes that as concerns underwriting risk, which is the principal insurance risk, undertakings may have a long history from which to assess applicable risk (e.g., longevity as applicable to life insurance).²²⁵

Insurers will elect to use internal modelling, as opposed to the standard model, when internal models help to lower the particular undertaking's SCR. However, as discussed above, an undertaking which decides to use partial or full internal modeling in respect of calculating SCR may only do so once such model has been reviewed and approved by the applicable supervisor, meeting various statistical, calibration, validation and documentation standards.²²⁶ In this regard, any internal model must also meet the so-called "use test" under Solvency II, a test which is described above and which provides for more developed standards than found under Basel II.²²⁷ Pursuant to this test, as discussed above, an undertaking must demonstrate that the particular model is widely used in and plays a significant role in the undertaking's actual internal risk management and decision-making processes. In other words, the undertaking must demonstrate that the model is not being used simply to minimize capital requirements or for the benefit of regulators, but rather that the model is actually being used as the basis upon which the business of the undertaking is being run.²²⁸

²²⁴ See Interview with Karel van Hulle, *supra* note 220.

²²⁵ *Id.*

²²⁶ See *supra* p. 13.

²²⁷ See Framework Directive, *supra* note 3, art. 120, at 57.

²²⁸ See *supra* p. 13.

4. Regulator Competence To Evaluate and Supervise Internal Models.

Another area of concern in respect of Solvency II is whether insurance supervisors will be adequately equipped to supervise internal models. In this regard, critics of the use of internal models often point to how the financial crisis has raised serious questions regarding the competence of financial supervisors to evaluate and monitor the proliferation of different internal models.

Unquestionably, internal modeling represents one of the most significant single challenges for insurance supervisors. Among other things, supervisors will need to possess the required technical knowledge, as well as understand how the various risks facing undertakings are modelled in order to evaluate the adequacy of any internal model. In this regard and to help facilitate uniformity across jurisdictions, the European Commission is currently developing uniform criteria which supervisors are to apply in respect of the approval of any internal model.²²⁹ In addition, extensive training sessions for national supervisors are being organized at the EU level as concerns internal modeling and related issues and risks.²³⁰

5. Addressing the Financial Crisis.

In light of the global financial crisis and the criticisms made in respect of Basel II (such criticisms frequently failing to take into account the differed implementation of Basel II), concerns have been raised as to whether, as a general matter, Solvency II adequately addresses the various challenges and issues presented by this crisis.

In this regard, it is important to bear in mind that Solvency II is not simply a reaction to the financial crisis, but rather represents an initiative which has been (and continues to be) an evolving revision of the prudential regulation of insurers. That having been said, many of the features of Solvency II position the initiative as a fundamental tool and platform for addressing many of the specific issues raised by the financial crisis. Perhaps one of the most significant ways in which Solvency II helps to address such issues is through the very nature of the initiative – a dynamic

²²⁹ See Comm. of Eur. Ins. & Occupational Pension Supervisors [CEIOPS], *CEIOPS' Advice for Level 2 Implementing Measures on Solvency II on: The Procedure to be Followed for the Approval of an Internal Model*, CEIOPS-Doc-28/09 (Oct. 2009).

²³⁰ See Interview with Karel van Hulle, *supra* note 220.

risk-based capital system based on enhanced governance and risk management. In this way, Mr. van Hulle stresses that Solvency II is able to address such matters as the serious shortcomings in risk management practices which have been exposed by the financial crisis. Furthermore, Solvency II (Pillar III) promotes greater transparency and accountability, another area of particular concern amplified by the financial crisis.

Moreover, and as discussed further herein, Solvency II aims to address the problem of pro-cyclicality, an area of notable concern with Basel II. In this regard and as discussed herein, the ladder of intervention approach adopted by Solvency II (the multi-tiered approach ranging from the SCR to the MCR) works to address possible pro-cyclical effects by providing for a graduated²³¹ and flexible approach²³² to supervisory intervention. In this way, Solvency II seeks to provide a dampener against the situation where the impact of regulation increases the severity on the overall economic, financial or insurance cycle.²³³

Various elements of Solvency II have been or are being considered for amendment as a direct result of the financial crisis. In this regard, Mr. van Hulle points to the possibility of attaching a greater importance to financial stability issues, strengthening Tier I capital requirements, and further addressing possible pro-cyclical effects as concerns supervisory actions, as well as specific risks, such as concentration risk or liquidity risk.²³⁴

Moreover, Mr. van Hulle identifies group supervision as an area of particular focus of the European Commission in light of the financial crisis, an area of supervision which has traditionally been treated as

²³¹ See *supra* p. 18-19..

²³² See Framework Directive, *supra* note 3, recital ¶ 61, at 6-7; art. 138(4), at 62-63. Solvency II provides that in the event of exceptional deterioration in the financial markets, supervisors may grant an undertaking additional time in order to re-establish the level of its own eligible funds to cover the SCR or reduce the undertaking's risk profile to ensure compliance with the SCR. *Id.*

²³³ See Comm. of Eur. Ins. & Occupational Pension Supervisors [CEIOPS], *Consultation Paper no. 64, Draft CEIOPS' Advice for Level 2 Implementing Measures on Solvency II: Extension of the Recovery Period*, CEIOPS-CP-64/09 (Nov. 2, 2009).

²³⁴ See Interview with Karel van Hulle, *supra* note 220; see also Basel Comm. on Banking Supervision, Bank for Int'l Settlements, *Enhancements to the Basel II Framework* (July 2009), available at <http://www.bis.org/publ/bcbsca.htm> (promulgating amendments designed to enhance the Basel II framework by strengthening minimum capital requirements and disclosure requirements).

supplementary to solo supervision throughout the EU (and the U.S.).²³⁵ Solvency II aims to prioritize group supervision along with solo supervision. In this regard, and as described herein, group supervision will be strengthened under Solvency II through such significant measures as the appointment by each group of a group supervisor.²³⁶

As an additional matter, the Value-at-Risk (VaR) approach adopted by Basel II, in part, has been criticized for failing to account for so-called “fat tail” events such as the financial crisis. In this regard, similar concerns have been raised as concerns Solvency II which also contemplates the use of VaR. Tail VaR is not currently contemplated to be included as part of the standard formula under Solvency II out of concerns that doing so would render the formula too complex.²³⁷ However, under Solvency II, undertakings are provided with the opportunity to specifically account for tail factors through the use of internal modelling. As discussed above, the use of internal models is particularly restricted under Basel II, whereas internal modelling is actively encouraged to be applied by any undertaking subject to Solvency II and across the spectrum or risks categories.

It is important to bear in mind that while capital requirements are key to any regulatory program, Solvency II takes a holistic approach to risk management, combining capital requirements with qualitative requirements (Pillar II) and market transparency measures (Pillar III). Therefore, the various risk-based measures of Solvency II, taken together on a regime-wide basis and as discussed in detail herein, are designed to help account for stress events.

While no economically viable regulatory regime can provide an absolute guarantee against failure, Solvency II is designed with the goal of striking the necessary balances. That being said, and as discussed above, Solvency II seeks to provide aggressive assurances as to the health of the insurance industry, in providing, for example, what is generally agreed to be a high confidence level of 99.5 % Value at Risk over a one-year period or one failure in two hundred years.

X. CONCLUSION

Solvency II is a fundamental review of the prudential regulation of the European insurance industry, providing for a reinforced EU-wide, forward-looking, risk-sensitive regulatory structure, as applicable to such

²³⁵ See Interview with Karel van Hulle, *supra* note 220.

²³⁶ See *supra* p. 12.

²³⁷ See Interview with Karel van Hulle, *supra* note 220.

areas as capital adequacy, governance and risk management, as well as market discipline and transparency. Through a total balance sheet approach, undertakings will be required under Solvency II not only to assess the actual risks faced by an undertaking, but also to implement such measures required to monitor, manage and mitigate such risks. Representing a further level of sophistication, Solvency II builds on the general architecture of Basel II, addressing the specificities of the insurance sector. Heading lessons from the financial crisis and the Basel framework, Solvency II, as a whole, is designed to play a key role in helping to provide an early warning system to reduce the likelihood of the collapse of insurance undertakings and losses being suffered by policyholders and beneficiaries.

**CONGRESS' SELF-INFLICTED SISYPHEAN TASK:
THE INSURANCE INDUSTRY'S FEDERAL ANTITRUST
EXEMPTION AND THE INSURANCE INDUSTRY
COMPETITION ACTS OF 2007 AND 2009**

Anthony J. Alt^{†*}

INTRODUCTION

[T]he law of insurance antitrust is not a subject for the faint of heart.¹

~Robert H. Jerry, II

In the aftermath of Hurricane Katrina, many people had ideas on how to lessen the impact of any such future catastrophe. One of those ideas concerned the insurance industry. Some people interpreted various actions of major insurance companies as attempts to avoid paying property-owner damage claims caused by Hurricane Katrina.² The simultaneous record-breaking profits of property-casualty companies in 2005³ made several Congressmen skeptical of the efficacy of state insurance regulation,⁴ and

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¹ Robert H. Jerry, II, *The Antitrust Implications of Collaborative Standard Setting by Insurers Regarding the Use of Genetic Information in Life Insurance Underwriting*, 9 CONN. INS. L.J. 397, 398 (2002–2003).

² See, e.g., Rep. Gene Taylor, *Federal Insurance Reform After Katrina*, 77 MISS. L.J. 783, 783–87 (2008) (describing the efforts of insurance companies to deny claims caused by wind damage); John K. Warren, Note, *Restoring Responsibility and Accountability in Disaster Relief*, 31 WM. & MARY ENVTL. L. & POL'Y REV. 893, 901 (2007) (purporting that some insurance companies delayed payments in order to force claimants into settling for lesser amounts).

³ AMERICANS FOR INSURANCE REFORM, *THE INSURANCE INDUSTRY'S TROUBLING RESPONSE TO KATRINA* 18 (2006) (noting that despite the hurricanes and claims losses, 2005 was the property-casualty industry's third greatest profit year in history).

⁴ See, e.g., Taylor, *supra* note 2, at 789 (stating that the antitrust exemption for the insurance industry should be repealed).

they decided it was time to revisit a favorite whipping horse: the McCarran-Ferguson Act's ("MFA") federal antitrust exemption for the insurance industry.⁵ Their consternation with the MFA recently took the form of two bills in Congress under the name of the Insurance Industry Competition Act of 2007, in an effort to repeal the MFA's federal antitrust exemption for the insurance industry.⁶ The present Congress has reintroduced an identical bill under the name of the Insurance Industry Competition Act of 2009.⁷

The MFA provides that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance."⁸ Further, the Sherman Act,⁹ Clayton Act,¹⁰ and Federal Trade Commission Act¹¹ are only "applicable to the business of insurance to the extent that such business is not regulated by State law."¹² The Sherman Act, however, is applicable to

⁵ McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015 (2006). The term "antitrust" appears to be limited to the United States. Brian Dean Abramson, *Let Them Eat Smoke: The Case for Exempting the Tobacco Industry from Antitrust*, 6 CARDOZO PUB. L. POL'Y & ETHICS J. 345, 353 n.44 (2008). Other countries use such terms as "competition" or "anti-monopoly" laws. *Id.*

⁶ S. 618, 110th Cong. (2007); H.R. 1081, 110th Cong. (2007).

⁷ H.R. 1583, 111th Cong. (2009).

⁸ 15 U.S.C. § 1012(b).

⁹ Sherman Act, 15 U.S.C. §§ 1–7 (2006). Section 1 of the Sherman Act contains a "restraint of trade" provision and states that "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is . . . illegal." *Id.* § 1. Section 2 contains a monopoly provision and states that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony." *Id.* § 2.

¹⁰ Clayton Act, 15 U.S.C. §§ 12–27 (2006). The Clayton Act was passed in an effort to address specific activities such as mergers and interlocking directorates of competing companies that have substantially anticompetitive effects on the market. 15 U.S.C. §§ 18–19.

¹¹ Federal Trade Commission Act, 15 U.S.C. §§ 41–58 (2006). The Act prohibits "[u]nfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce." 15 U.S.C. § 45(a)(1). The Act established the Federal Trade Commission to prevent persons or entities from engaging in any unfair or deceptive acts. *Id.* §§ 41, 45.

¹² 15 U.S.C. § 1012(b).

any agreement or act involving boycott, coercion, or intimidation regardless of state law.¹³

Questioning of the MFA federal antitrust exemption for the insurance industry is nothing new. Various groups have looked askance at the exemption for decades, and proposals have on occasion been introduced in an effort to repeal it or limit its scope. For example, the U.S. Department of Justice issued a report in 1977 concluding that the insurance industry did not need exemption from federal antitrust laws, and that regulation without the MFA exemption would be desirable.¹⁴ That same year, Congress considered an optional federal charter for insurance companies and greater application of federal antitrust laws with the Federal Insurance Act of 1977, but ultimately rejected the idea.¹⁵ In 1979, the National Commission for the Review of Antitrust Laws and Procedures stated in a report that the insurance antitrust exemption in the MFA should be repealed.¹⁶ In 1987, a flurry of activity in the Senate was aimed at repealing or modifying the MFA antitrust exemption, none of which was successful.¹⁷ The Insurance Competition Improvement Act was proposed in 1989 to modify the exemption by providing a list of activities that would be exempt, making the federal antitrust laws applicable to all other activities.¹⁸ In 1993, the charge to repeal the exemption took the form of the Insurance Competitive Pricing Act of 1993—an effort to prohibit insurers from price fixing, allocating regions among competitors, engaging

¹³ *Id.* § 1013(b).

¹⁴ U.S. DEP'T OF JUSTICE, THE PRICING AND MARKETING OF INSURANCE: REPORT OF THE U.S. DEPARTMENT OF JUSTICE TO THE TASK GROUP ON ANTITRUST IMMUNITIES 30–31 (1977).

¹⁵ Federal Insurance Act of 1977, S. 1710, 95th Cong. (1977).

¹⁶ U.S. NAT'L COMM'N FOR THE REVIEW OF ANTITRUST LAWS AND PROCEDURES, REPORT TO THE PRESIDENT AND THE ATTORNEY GENERAL OF THE NATIONAL COMMISSION FOR THE REVIEW OF ANTITRUST LAWS AND PROCEDURES 225 (1979).

¹⁷ See S. 80, 100th Cong. (1987) (introduced by Sen. Metzenbaum to repeal MFA; in introducing the bill, he indicated that the “McCarran-Ferguson Act has long outlived whatever legitimate purpose it served,” 133 CONG. REC. 542 (1987)); S. 804, 100th Cong. (1987) (introduced to modify the antitrust exemption section of MFA); S. 1299, 100th Cong. (1987).

¹⁸ Insurance Competition Improvement Act of 1989, S. 719, 101st Cong. (1989).

in tying arrangements, and monopolizing any part of the insurance industry.¹⁹

Ten years later, a similar bill was introduced under the same name, with the only difference being the year: the Insurance Competitive Pricing Act of 2003.²⁰ That same year, the Medical Malpractice Insurance Antitrust Act of 2003 was introduced in Congress as an attempt to narrowly modify MFA by addressing price-fixing, bid-rigging, and market allocations with respect to medical malpractice insurance.²¹ Two years later, the Insurance Competitive Pricing Act of 2005 was introduced in the House of Representatives in an effort to repeal the exemption while providing safe harbors for certain activities.²²

Recently, the Antitrust Modernization Commission released a report questioning the MFA exemption.²³ The report strongly recommended that the insurance industry should not be singled out in order to avoid federal antitrust compliance and litigation costs.²⁴ It also stated that arguments attempting to justify the MFA exemption based on the claim that it is necessary in order to provide stable prices and ensure insurer solvency are unpersuasive since “[t]he costs of price ‘stability’ typically flow to consumers and result in inflexibility that undermines economic growth.”²⁵ The Commission viewed the insurance antitrust exemption as unnecessary and recommended that all insurance activity should instead be subject to a rule of reason analysis that weighs pro-competitive benefits with any anticompetitive elements.²⁶ Ultimately, the Commission placed the onus on the insurance industry to justify its federal antitrust exemption and to prove why it is still necessary.²⁷

Therefore, the Insurance Industry Competition Act of 2007 was, on the one hand, like a phoenix risen yet again from the ashes—it was nothing

¹⁹ Insurance Competitive Pricing Act of 1993, H.R. 9, 103d Cong. (1993); Insurance Competitive Pricing Act, S. 84, 103d Cong. (1993).

²⁰ Insurance Competitive Pricing Act of 2003, H.R. 448, 108th Cong. (2003).

²¹ Medical Malpractice Insurance Antitrust Act of 2003, S. 352, 108th Cong. (2003).

²² Insurance Competitive Pricing Act of 2005, H.R. 2401, 109th Cong. (2005).

²³ ANTITRUST MODERNIZATION COMM’N, REPORT AND RECOMMENDATIONS 350 (2007).

²⁴ *Id.* at 351.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.* at 354. The Commission also noted that other countries require ongoing proof and justification for any exemption, which must be analyzed in present market conditions to see if it should be abolished. *Id.* at 385 n.123.

new. On the other hand, it is perplexing that the MFA federal antitrust exemption remains intact when it has been repeatedly questioned for decades. After so many groups have called for the repeal or modification of the exemption, and given feasible alternatives that can be applied in modern market conditions, now is an appropriate time to reassess the purpose and necessity of the MFA exemption along with the needs of the insurance industry and consumers. This Article suggests that the current understanding and application of the MFA exemption differ from Congress's original intent, that proponents of the MFA exemption have not sufficiently demonstrated a continued need for it, and that the exemption is not the most effective way to protect the best interests of consumers. Accordingly, the ideas contained in this latest legislation—the Insurance Industry Competition Act of 2007, and recently reintroduced in Congress as the Insurance Industry Competition Act of 2009—should not be dismissed as yet another Sisyphean attempt by Congress. Rather, the ideas from the bill should be seriously considered, though adapted in a new form of legislation, in order to modify MFA's antitrust exemption for the insurance industry. Other commentators have suggested how the MFA exemption could be modified, but there is a noticeable absence of literature from the legal community on the approach embodied in the Insurance Industry Competition Act of 2007 and 2009. This Article analyzes the underpinnings of the Acts and shows why they are different from other ways to modify the MFA exemption that have been suggested.

In order to understand why the Insurance Industry Competition Act of 2007 should have been considered and why the Insurance Industry Competition Act of 2009 should be seriously considered, or more broadly, why the MFA antitrust exemption should be modified, it is necessary to understand the evolution of insurance regulation in the United States leading up to the MFA. Part I of this Article, therefore, provides the historical backdrop to the MFA and its antitrust exemption for the insurance industry. Part II discusses the passing of the McCarran-Ferguson Act, the purpose and intent behind it, along with the developing understanding of the exemption, and provides an analysis of its current meaning and effectiveness. Part III argues that the federal antitrust exemption for the insurance industry in its present form has strayed from Congress's original purpose and intent, is not the most effective way to protect the best interests of consumers, is unnecessary in modern market conditions, and should be modified. It concludes by advocating the implementation of legislation similar to the Insurance Industry Competition Act of 2007 and the Insurance Industry Competition Act of 2009, though in a modified form by providing advisory and regulatory authority to the

Department of Justice and the Federal Trade Commission, along with express safe harbor activities for insurance companies in order for them to operate efficiently while protecting the best interests of consumers and maintaining a balance between state regulation and federal oversight.

I. THE HISTORICAL BACKDROP TO THE MCCARRAN-FERGUSON ACT

The relationship between federal antitrust policy and state economic regulation is driven . . . by attitudes toward regulation.²⁸

~Herbert Hovenkamp

A. THE INSURANCE INDUSTRY IN THE UNITED STATES, 1700S–1868

The insurance industry and the development of insurance regulation have a colorful history in the United States, largely woven by the threads of a uniquely competitive entrepreneurial drive.²⁹ The first form of insurance introduced in the United States was marine insurance for the shipping industry.³⁰ Fire insurance soon became prevalent, with Benjamin Franklin and others organizing the first fire insurance company, the Philadelphia Contributionship for the Insuring of Houses from Loss by Fire, in 1752.³¹ Nevertheless, only a limited number of entities engaged in the insurance business before 1776, due in part to restrictive British legislation that prohibited non-English stock insurance companies from being established in the United States.³²

Subsequent to the Revolutionary War and the end of British rule, however, insurance companies in the United States were no longer limited

²⁸ Herbert Hovenkamp, *Federalism and Antitrust Reform*, 40 U.S.F. L. REV. 627, 630 (2006).

²⁹ It is beyond the scope of this Article to discuss the history of insurance outside of the United States. For a comprehensive overview of the origins and development of insurance in ancient times, see generally W.R. Vance, *The Early History of Insurance Law*, 8 COLUM. L. REV. 1 (1908).

³⁰ Lissa L. Broome & Jerry W. Markham, *Banking and Insurance: Before and After the Gramm-Leach-Bliley Act*, 25 J. CORP. L. 723, 726 (2000).

³¹ See *id.*

³² Laurence M. Hamric, *The McCarran-Ferguson Act: A Time for Procompetitive Reform*, 29 VAND. L. REV. 1271, 1272 & n.5 (1976).

to organizing themselves as mutual companies or voluntary associations.³³ In 1787, the horizons broadened for the industry when the Baltimore Fire Insurance Company became the first stock insurance company in the United States.³⁴ The primary method of organizing an insurance company during the late 1700s and early 1800s was through state legislatures granting special charters for insurance companies, beginning in 1794 in Pennsylvania with the incorporation of the Insurance Company of North America.³⁵ At that time, insurance companies were relatively easy to start and they could charge whatever premium they wanted.³⁶ The relative ease in starting an insurance company, combined with no regulatory oversight in the setting of premiums, was both a blessing and a curse.

Insurance companies' disparate approaches to the charging of premiums in efforts to oust competition unsurprisingly resulted in significant problems. For instance, with respect to the fire insurance industry alone, the period from 1791 to 1850 resulted in a net loss for companies.³⁷ Only 1000 of the fire insurance companies out of the 4000 that had been started prior to 1877 survived.³⁸ Nevertheless, some insurance companies made efforts as early as 1806 to increase profitability and lessen price competition by making informal agreements to fix premium rates.³⁹ The number of rate-making agreements expanded for the next thirteen years, resulting in the establishment of local associations that companies would join, with member companies binding themselves to only charge rates that had been agreed upon.⁴⁰ These early efforts by fire insurance companies and property-casualty companies at establishing some sort of standardized rates,⁴¹ however, were somewhat thwarted by

³³ See JOHN G. DAY, ECONOMIC REGULATION OF INSURANCE IN THE UNITED STATES 3 (1970) (noting that the first forms of entities providing insurance prior to the Revolutionary War were individual underwriters, voluntary associations, and mutual companies).

³⁴ MARY ELIZABETH RUWELL, EIGHTEENTH-CENTURY CAPITALISM: THE FORMATION OF AMERICAN MARINE INSURANCE COMPANIES 44 (1993).

³⁵ Hamric, *supra* note 32, at 1272–73.

³⁶ Spencer L. Kimball & Ronald N. Boyce, *The Adequacy of State Insurance Rate Regulation: The McCarran-Ferguson Act in Historical Perspective*, 56 MICH. L. REV. 545, 547 (1958).

³⁷ *Id.* at 548.

³⁸ *Id.* at 547–48.

³⁹ *Id.* at 548.

⁴⁰ *Id.*

⁴¹ See Hamric, *supra* note 32, at 1273.

companies that charged such low rates that they did not even cover contractual obligations when they came due.⁴²

The highly competitive nature that was present during the early 1800s in the insurance industry resulted in a need for regulation imposed from outside of the industry.⁴³ Insurance companies in the United States were largely unhindered by governmental control and regulation during that time. Insurance regulation was done on the state level, and consisted of restrictions built into insurance company charters which contained financial reporting requirements, loss-claim reserve provisions, restrictions on investments, and minimum capitalization requirements.⁴⁴ These restrictions and requirements, however, did not regulate rates, and were largely ineffective since the states had a conflict of interest in enforcing them.⁴⁵ The penalty for insurance companies violating their charter provisions was for the state to prevent the companies from conducting business within its boundaries—a course of action states were disinclined to follow since it would have reduced jobs for its citizens and decreased taxes revenues.⁴⁶ After 1837, state regulation of insurance through restrictions built into company charters became even more ineffective due to states abandoning such charters; instead, states began adopting general incorporation requirements for new companies.⁴⁷

Some states, however, did try to adopt a more active regulatory stance toward the industry, though they directed their efforts primarily at foreign insurance companies rather than domestic ones. For instance, in 1824, New York imposed reporting requirements on foreign companies,⁴⁸ and in 1827, Massachusetts mandated that foreign companies file a copy of their charters with the state along with information concerning their stock,

⁴² Irwin M. Stelzer, *The Insurance Industry and the Antitrust Laws: A Decade of Experience*, 1955 INS. L.J. 137, 141 (1955).

⁴³ Hamric, *supra* note 32, at 1273. See also Stelzer, *supra* note 42, at 141 (describing the industry between 1835 through the Civil War as being characterized by “keen competition”).

⁴⁴ Katherine M. Jones, *Law, Politics, and the Political Safeguards of Federalism: The Case of Insurance Regulation and the Commerce Clause, 1938–1948*, 11 CONN. INS. L.J. 345, 356 & n.53 (2004–2005).

⁴⁵ *Id.* at 356.

⁴⁶ *Id.*

⁴⁷ See Peter R. Nehemkis, Jr., *Paul v. Virginia: The Need for Re-Examination*, 27 GEO. L.J. 519, 523 n.17 (1939) (indicating that after 1837, the primary way of incorporation an insurance company shifted from the granting of special charters to general incorporation laws).

⁴⁸ *Id.* at 523.

debts, and investments.⁴⁹ Other states imposed restrictions and penalties on foreign insurance companies in addition to levying taxes and requiring companies to pay fees in connection with forced loans, required deposits, licenses, and advertising, much to the chagrin of the companies.⁵⁰ These regulations and restrictions, however, were not uniform from state to state.⁵¹

With the advent of the 1850s came the creation of a few regulatory state agencies, while the federal government remained uninvolved with the industry.⁵² The appointment of the first state insurance commissioner occurred in 1850.⁵³ In 1855, Massachusetts created a board of insurance commissioners, and New York established the position of the Superintendent of Insurance in 1859.⁵⁴ The growth in state regulation became an increasing irritation for insurance companies, who regarded the increased oversight and various restrictions and taxes on foreign companies as unconstitutional and unjust.⁵⁵

In spite of burgeoning state regulation, the insurance industry experienced an enormous growth in the number of companies during the 1860s.⁵⁶ Accompanying this rapid growth, however, were questionable practices aimed at squeezing out competitors, including misleading advertising, false information about stocks and capital,⁵⁷ and the continued practice of charging unprofitable premium rates.⁵⁸ After the end of the Civil War, two noteworthy events occurred with respect to the industry's two primary concerns—state regulation and competition. First, the insurance industry sought to rid itself of state regulation by lobbying Congress for a national bureau of insurance⁵⁹ in order to obtain one uniform set of governmental regulations.⁶⁰ In addition, the first attempt at setting uniform rates on a national basis was made when the fire insurance

⁴⁹ *Id.* at 523-24.

⁵⁰ Nehemkis, *supra* note 47, at 524 & n.26.

⁵¹ See DAY, *supra* note 33, at 20-23.

⁵² See Michael D. Rose, *State Regulation of Property and Casualty Insurance Rates*, 28 OHIO ST. L.J. 669, 677 (1967).

⁵³ *Id.*

⁵⁴ Nehemkis, *supra* note 47, at 524.

⁵⁵ *Id.*

⁵⁶ *Id.* at 520.

⁵⁷ *Id.* at 520-21.

⁵⁸ Stelzer, *supra* note 42, at 141.

⁵⁹ Rose, *supra* note 52, at 673.

⁶⁰ Nehemkis, *supra* note 47, at 525.

industry created the National Board of Fire Underwriters,⁶¹ simultaneous to the creation of regional rate associations.⁶² These events signified a common perspective and approach within the industry that would influence its actions for the next seventy-five years: they established the precedent of insurance companies seeking national regulation and collaboration.

The industry's attempts to have Congress create a national bureau of insurance were prompted in part by the National Banking Act of 1864—insurance companies wanted to be federal institutions like national banks and rid themselves of state legislation, which they viewed as excessive and oppressive to foreign companies.⁶³ Although the insurance industry was able to get two bills introduced into Congress, neither of them were successful.⁶⁴ The industry remained undeterred and sought a different venue for ridding itself of state regulation: the courts. The National Board of Fire Underwriters partnered with the Underwriters' Agency of New York in order to support a case in court challenging the constitutionality of state regulation of insurance.⁶⁵ This effort resulted in the case *Samuel B. Paul v. Commonwealth of Virginia*.⁶⁶

B. 1868: SAMUEL B. PAUL V. COMMONWEALTH OF VIRGINIA

Virginia had passed a statute in 1866 that required foreign insurance companies to deposit a bond ranging between \$30,000 and \$50,000 with the state prior to receiving a license in order to conduct business within Virginia.⁶⁷ A related statute required that no person could act as an agent for a foreign insurance company in Virginia without a license.⁶⁸ Paul was an agent for several insurance companies incorporated in New York, and applied for a license as their agent, but he and the

⁶¹ Stelzer, *supra* note 42, at 141.

⁶² Jones, *supra* note 44, at 357. These regional and national efforts of companies to set uniform rates went on without regulatory supervision despite their anticompetitive nature. *Id.*

⁶³ Nehemkis, *supra* note 47, at 524–25.

⁶⁴ S. 299, 40th Cong., (2d Sess. 1868); H.R. 738, 39th Cong., (1st Sess. 1866). The proposed National Bureau of Insurance would have included a National Insurance Commissioner appointed by the President, and a section of the Treasury Department which would have handled all regulatory transactions involving money. Nehemkis, *supra* note 47, at 525.

⁶⁵ Nehemkis, *supra* note 47, at 526–27.

⁶⁶ 75 U.S. 168 (1868).

⁶⁷ *Id.* at 168.

⁶⁸ *Id.* at 169.

companies refused to post the required bond.⁶⁹ Although the State of Virginia refused to grant him a license as an agent to conduct insurance business within the state, Paul issued a policy to a Virginia citizen in violation of the state's statutes, and was subsequently indicted.⁷⁰ The National Board of Fire Underwriters provided and funded two highly prominent attorneys (one of them a former Justice of the U.S. Supreme Court) to represent Paul and the interests of the insurance industry.⁷¹

Paul and the insurance industry challenged the statutes under the Privileges and Immunities Clause⁷² by claiming that the foreign insurance companies were citizens and should not be subject to discriminatory state legislation that was not applicable to domestic companies.⁷³ They also argued that the statute was unconstitutional by claiming that insurance was interstate commerce, exclusively subject to the regulation of Congress based on the Commerce Clause,⁷⁴ and therefore the states lacked authority to regulate the activity.⁷⁵ The Court rejected the arguments and declared the statute constitutional by holding that the insurance companies were not "citizens" under the Privileges and Immunities Clause, and that "[i]ssuing a policy of insurance is not a transaction of commerce" or an interstate transaction for purposes of the Commerce Clause, thereby leaving Congress without authority to regulate the industry.⁷⁶ As a result, *Paul* temporarily ensured continued state regulatory authority over the insurance industry to the exclusion of federal oversight.

C. INSURANCE REGULATION: 1869 TO 1944

Despite the decision in *Paul*, the insurance industry continued its challenges of the constitutionality of state regulation of insurance. There

⁶⁹ *Id.* One commentator has suggested that Paul's refusal to post the bond when applying for his license was due to instructions from the four insurance companies he represented, presumably in connection with the Underwriters Agency of New York and the National Board of Fire Underwriters. Nehemkis, *supra* note 47, at 526–27.

⁷⁰ *Paul*, 75 U.S. at 169.

⁷¹ Nehemkis, *supra* note 47, at 527–28.

⁷² U.S. CONST. art. IV, § 2.

⁷³ *Paul*, 75 U.S. at 170–71.

⁷⁴ U.S. CONST. art. 1, § 8, cl. 3 ("Congress shall have Power . . . To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes").

⁷⁵ *Paul*, 75 U.S. at 170, 172.

⁷⁶ *Id.* at 177, 183.

were ten different Supreme Court cases between 1869 and 1927 that challenged state regulation or taxation, but the Court consistently held that insurance activities were not interstate commerce.⁷⁷ In addition, repeated legislative attempts were made in Congress to create a national bureau of insurance and classify insurance activities as interstate commerce, but none were successful.⁷⁸ Committees in Congress also considered, but rejected, various resolutions advocating a constitutional amendment that would have allowed Congress to exercise regulatory authority over insurance.⁷⁹ The industry's incessant drive for federal regulation, whether right or wrong, was likely because it "considered it more advantageous to be regulated by a toothless, laissez-faire mastiff like the Federal Government than by those smaller but possibly more harassing watch dogs, the individual states."⁸⁰

Because *Paul* and its progeny held that issuing an insurance policy was not interstate commerce, when Congress passed the Sherman Act in 1890 based on authority from the Commerce Clause declaring any agreement, contract, combination, or conspiracy in restraint of trade or interstate commerce as illegal,⁸¹ the insurance industry did not think that a federal antitrust law such as the Sherman Act was applicable to insurance.⁸² This view was reinforced in 1913 by the Supreme Court espousing mutual exclusivity between state and federal regulation (dual federalism⁸³) in *New*

⁷⁷ See *Bothwell v. Buckbee, Mears Co.*, 275 U.S. 274, 276–77 (1927); *Nw. Mut. Life Ins. Co. v. Wisconsin*, 247 U.S. 132, 137–38 (1918); *N. Y. Life Ins. Co. v. Deer Lodge County*, 231 U.S. 495, 510–11 (1913); *Nutting v. Massachusetts*, 183 U.S. 553, 556–58 (1902); *N. Y. Life Ins. Co. v. Cravens*, 178 U.S. 389, 401 (1900); *Noble v. Mitchell*, 164 U.S. 367, 370–71 (1896); *Hooper v. California*, 155 U.S. 648, 655–56 (1895); *Phila. Fire Ass'n v. New York*, 119 U.S. 110, 118 (1886); *Liverpool Ins. Co. v. Massachusetts*, 77 U.S. 566, 573, 576 (1870); *Ducat v. Chicago*, 77 U.S. 410, 415 (1870).

⁷⁸ *U.S. v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 576 & n.8 (1944) (Stone, C.J., dissenting) (listing several bills introduced between 1899 and 1906 in the House and Senate).

⁷⁹ *Id.* at 579 & n.13.

⁸⁰ Sigmund Timberg, *Insurance and Interstate Commerce*, 50 YALE L.J. 959, 969 n.42 (1941).

⁸¹ Sherman Act, ch. 647, § 1, 26 Stat. 209 (1890) (codified at 15 U.S.C. § 1 (2006)).

⁸² Larry D. Carlson, *The Insurance Exemption from the Antitrust Laws*, 57 TEX. L. REV. 1127, 1130 (1979).

⁸³ Dual federalism is "a system for dividing functions between the state and national government that left each considerable autonomy within its own areas of jurisdiction." David R. Beam et al., *Federalism: The Challenge of Conflicting*

York Life Insurance Company v. Deer Lodge County when it stated that “if insurance is commerce and becomes interstate commerce whenever it is between citizens of different States, then all control over it is taken from the States, and the legislative regulations which this court has heretofore sustained must be declared invalid.”⁸⁴

Accordingly, the industry’s view of itself as exempt from federal antitrust law presumably did not change in 1914 with the passing of the Clayton Act⁸⁵ and Federal Trade Commission Act.⁸⁶ Therefore, the various insurance companies that exchanged actuarial data and engaged in price fixing and boycotting of companies not part of member association groups continued in their ways.⁸⁷ To justify their activities, the insurance industry claimed that unrestricted competition without some collaboration among companies would create a plethora of undesirable results such as unsustainable premium rate competitions and inadequate reserves for the payment of claims.⁸⁸ Although some states tried to enforce legislation against the sharing of actuarial information and collaborative rate setting, their efforts were largely ineffective.⁸⁹ Instead of trying to make rate setting illegal, they began passing legislation to regulate rates, often accompanied by antimonopoly prohibitions.⁹⁰ State regulation of rates, however, was intended primarily to guard against insurance companies from becoming insolvent by charging unsustainably low premiums, not to cap excessive rates.⁹¹

In 1915, however, an unusual twist to the exclusivity of state regulation of insurance occurred. The Supreme Court in *Thames & Mersey Marine Insurance Company, Ltd. v. United States* invalidated the federal

Theories and Contemporary Practice, in POLITICAL SCIENCE: THE STATE OF THE DISCIPLINE 247, 248 (Ada W. Finifter ed., 1983).

⁸⁴ *N.Y. Life Ins. Co. v. Deer Lodge County*, 231 U.S. 495, 509 (1913).

⁸⁵ Clayton Act, 38 Stat. 730 (1914) (codified as amended at 15 U.S.C. §§ 12–27 (2006)).

⁸⁶ Federal Trade Commission Act, ch. 311, 38 Stat. 717 (1914) (codified as amended at 15 U.S.C. §§ 41–58 (2006)).

⁸⁷ See Carlson, *supra* note 82, at 1130 (describing the companies as “confident” that their activities remained immune from federal antitrust laws).

⁸⁸ DAY, *supra* note 33, at 20–21.

⁸⁹ *Id.* at 19. Cf. Jones, *supra* note 44, at 359 (indicating that nearly all state insurance commissions were inadequately funded).

⁹⁰ See Rose, *supra* note 52, at 681–82 (describing the states’ approach to collaborative efforts among insurance companies, and indicating that by 1944, thirty-three states had provisions to regulate rates).

⁹¹ Jones, *supra* note 44, at 359.

stamp tax on ocean marine insurance policies since it viewed “insurance during the voyage” as an “integral part of the exportation” due to “the demands of commerce.”⁹² Marine insurance companies worried that the decision could be interpreted as making federal antitrust laws applicable to insurance under the Commerce Clause.⁹³ The companies, therefore, lobbied Congress to expressly exempt the marine insurance industry from federal antitrust laws.⁹⁴ Congress considered the marine insurance industry unique given its international implications, and in a pragmatic and precedential move exempted the marine insurance industry from all federal antitrust laws in the Merchant Marine Act of 1920,⁹⁵ primarily for reinsurance and international underwriting purposes.⁹⁶ The collaborative efforts among the insurance companies continued largely unhindered,⁹⁷ and the precedent for a statutory exemption from federal antitrust laws was established for the insurance industry.

The events of the 1930s opened the door slightly to the possibility of change to government regulation of the industry. The Great Depression prompted Congress to pass new economic regulations, and the Supreme Court began lifting its restrictive view of Congress’s ability to regulate economic issues.⁹⁸ In 1938, President Roosevelt initiated an in-depth antimonopoly investigation, and the Temporary National Economic Committee analyzed the state of competition in the insurance industry.⁹⁹ The Committee made several findings. Notably, it found that states were

⁹² *Thames & Mersey Marine Ins. Co. v. United States*, 237 U.S. 19, 26 (1915).

⁹³ *See* Rose, *supra* note 82, at 675.

⁹⁴ *Id.*

⁹⁵ Merchant Marine Act, ch. 250, § 29, 41 Stat. 988, 1000 (codified as amended at 15 U.S.C. § 38 (2006)).

⁹⁶ Rose, *supra* note 82, at 675–76. Over four decades later, the Senate Subcommittee on Antitrust and Monopoly reexamined the exemption for marine insurance and expressed great concern about a virtual monopoly in hull insurance and agreements that severely limited entry into the market and discouraged price competition. *Id.* at 676.

⁹⁷ *See* Hamric, *supra* note 32, at 1275 (indicating that state enforcement and regulation left the insurance “compact system” intact).

⁹⁸ *See Nat’l Labor Relations Bd. v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 37–38 (1937) (holding that Congressional authority to regulate commerce is plenary and extends to intrastate activities if “they have such a close and substantial relation to interstate commerce that their control is essential or appropriate to protect that commerce from burdens and obstructions”); Jones, *supra* note 44, at 365.

⁹⁹ Jones, *supra* note 44, at 370–71.

struggling to regulate the insurance industry because of the concentration of business in only a handful of companies and the interstate activities of the companies.¹⁰⁰ Five life insurance companies accounted for more than 50% of the industry's resources; 87% of all life insurance assets were owned by the twenty-five largest life insurance companies.¹⁰¹ To remedy the high level of concentration in the industry among the largest companies, the Committee proposed greater enforcement of antitrust provisions for prosecuting anti-competitive behavior while retaining state regulation of the industry in general.¹⁰²

Little changed, however, until Thurman Arnold was put in charge of the Antitrust Division of the Justice Department.¹⁰³ Arnold initiated an effort to address insurance abuses at the national level.¹⁰⁴ In 1942, the Justice Department filed suit against South-Eastern Underwriters Association, a regional group made up of approximately 200 fire insurance companies, for violating sections 1 and 2 of the Sherman Act by controlling 90% of the fire insurance market in six states through conspiracies to fix premiums and boycott non-member companies.¹⁰⁵ The district court dismissed the case based on the precedent from *Paul v. Virginia*, which held that insurance was not interstate commerce or trade.¹⁰⁶ On appeal, the Supreme Court continued its broadened approach from *Wickard v. Filburn* in interpreting the Commerce Clause¹⁰⁷ and maintained its view from *Parker v. Brown* that state and national authority can be exercised concurrently.¹⁰⁸ The Court effectively overruled *Paul v. Virginia* by holding that insurance is interstate commerce and is subject to the

¹⁰⁰ *Id.* at 371, 373.

¹⁰¹ *Id.* at 371.

¹⁰² *See id.* at 373 (noting that the Committee's final report stated that federal power should be utilized and antitrust prosecution should be "pursued more vigorously").

¹⁰³ *Id.* at 360.

¹⁰⁴ *Id.*

¹⁰⁵ *United States v. South-Eastern Underwriters Ass'n*, 51 F. Supp. 712, 713 (N.D. Ga. 1943), *rev'd*, 322 U.S. 533, 534–35 (1944).

¹⁰⁶ *Id.* at 714–15.

¹⁰⁷ *See Wickard v. Filburn*, 317 U.S. 111, 128–29 (1942) (holding that Congress's power to regulate commerce extends to growing home-consumed wheat and any other activities that have a "substantial influence on price and market conditions").

¹⁰⁸ *Parker v. Brown*, 317 U.S. 341, 368 (1943).

legislative powers of Congress under the Commerce Clause, including the Sherman Act, which forbids premium rate-fixing agreements.¹⁰⁹

As a result of the Court's decision, the insurance industry's long-desired hope for federal regulation turned into fear. The industry presumed that as a result of the decision in *South-Eastern Underwriters Association*, the federal government would pass legislation requiring greater competition and apply federal antitrust laws, resulting in the bankruptcy of a large number of companies.¹¹⁰ Some insurance companies tried to use the decision to their advantage by refusing to follow state regulation or pay state taxes by claiming that such restraints on interstate commerce now violated the Constitution.¹¹¹

II. THE MCCARRAN-FERGUSON ACT AND THE INSURANCE INDUSTRY ANTITRUST EXEMPTION: WHAT IT MEANT THEN AND WHAT IT MEANS NOW

The continued state regulation of insurance throughout the twentieth century is an historical anomaly.¹¹²

~Katherine M. Jones

A. THE MCCARRAN-FERGUSON ACT OF 1945

Before the Supreme Court had decided *South-Eastern Underwriters Association*, Representative Walter introduced the Walter-Hancock bill in Congress in order to expressly ensure continued state regulation of insurance and entirely exempt insurance from federal antitrust regulation.¹¹³ The House of Representatives passed the bill, but it did not pass in the Senate.¹¹⁴ An important reason the bill did not pass was that it

¹⁰⁹ *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 560-61 (1944).

¹¹⁰ Jones, *supra* note 44, at 381.

¹¹¹ S. REP. NO. 20, 79th Cong., 1st Sess., at 2 (1945); H.R. REP. NO. 143, 79th Cong., 1st Sess., at 2 (1945); 91 CONG. REC. 478-79 (1945). *See also* Charles D. Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 DUKE L.J. 587, 591 (1978) (indicating that there were protests in thirty-one states).

¹¹² Jones, *supra* note 44, at 355.

¹¹³ H.R. 3270, 78th Cong., (1st Sess 1943).

¹¹⁴ 90 CONG. REC. 8054 (1944).

enjoyed little support from the insurance industry.¹¹⁵ In fact, the National Association of Insurance Commissioners (NAIC) *opposed* the notion of completely exempting the insurance industry from federal antitrust laws.¹¹⁶

After the bill did not pass, the NAIC released a report emphasizing the need for continued state regulation of insurance, but asked for only a partial exemption from federal antitrust laws for certain activities.¹¹⁷ NAIC's primary concern was to preserve state regulation and taxation of insurance.¹¹⁸ NAIC made a proposal to the Senate to avoid unrestricted competition, and to allow for collaborative practices within the industry that were proclaimed to be in the public interest.¹¹⁹

Section 2(a) of the NAIC's proposal provided for the retention of state regulation and taxation of insurance.¹²⁰ Section 2(b) prevented all federal law from invalidating, impairing, or superseding any state laws regulating insurance.¹²¹ Section 3 called for an exemption from the Federal Trade Commission Act and Robinson-Patman Act.¹²² Section 4(a) provided a moratorium during which the Sherman Act and Clayton Act would not apply, though Section 4(c) made the Sherman Act applicable during the moratorium to acts of boycott, coercion, or intimidation.¹²³ Section 4(b) proposed exempting seven activities: (1) any agreement or concerted or cooperative action which prescribed the use of rates; (2) the use of those rates; (3) any cooperative or joint service, adjustment, investigation, or inspection agreement relating to insurance; (4) any agreement or concerted or cooperative action among two or more insurers to insure, reinsure, or otherwise apportion the risks; (5) any agreement or concerted action with respect to the payment of insurance agents or brokers; (6) any agreement or concerted action with respect to the collection and use of statistics; and (7) any agreement or concerted action providing for the cooperative making of insurance rates, rules, or plans.¹²⁴

¹¹⁵ Weller, *supra* note 111, at 592 n.34.

¹¹⁶ *Id.* The NAIC is comprised of state insurance commissioners. As such, it is notable that the NAIC was initially not a proponent of a broad exemption from federal antitrust laws.

¹¹⁷ *Id.* at 594.

¹¹⁸ *Id.* at 598.

¹¹⁹ *Id.* at 594.

¹²⁰ *Id.*

¹²¹ Weller, *supra* note 111, at 594.

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.*

The result of the NAIC's proposal was, like many proposals for legislation, a catalyst for compromise. There was great debate between those who had previously supported the approach of total exemption from federal antitrust laws embodied in the Walter-Hancock bill, and those who supported the NAIC's approach of providing limited exemptions based on the seven express safe harbor activities.¹²⁵ Senators Ferguson and McCarran supported the NAIC's approach; they modified and proposed it under the form of S. 340 by deleting the exempted activities specified in section 4(b) of the NAIC's proposal, and by specifying that the Sherman and Clayton Acts cannot invalidate, impair, or supersede state laws.¹²⁶

The Senate made several amendments to the bill which the House of Representatives did not include in its approved version of the bill, and the result was a major modification of the bill in the joint conference committee.¹²⁷ The committee removed the exemption from the Federal Trade Commission Act and the Robinson-Patman Act, provided that there would be a moratorium during which the Sherman, Clayton, and Federal Trade Commission Acts would not apply, but after which they would apply "to the extent that such business is not regulated by state law."¹²⁸ The House voted in support of the modified version of the bill without debate, and the Senate adopted it less than a week later.¹²⁹ President Roosevelt signed the modified version of S. 340 into law on March 9, 1945,¹³⁰ which has become known as the McCarran-Ferguson Act. The final version made into law indicates that the primary purpose of the Act was to preserve state regulation of insurance:

Congress hereby declares that the *continued regulation and taxation by the several States of the business of insurance is in the public interest*, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.¹³¹

¹²⁵ *Id.* at 595.

¹²⁶ *Id.* at 595–96.

¹²⁷ Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 WM. & MARY L. REV. 81, 87 (1983).

¹²⁸ 91 CONG. REC. 1396 (1945).

¹²⁹ *Id.* at 1396, 1442–44, 1477–89.

¹³⁰ *Id.* at 1992.

¹³¹ 15 U.S.C. § 1011 (2006) (emphasis added).

The MFA further expressly subjects insurance to the continued oversight of state regulation by providing that:

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.¹³²

These sections of the MFA were intended to alleviate conflicts between state regulation and taxation of the insurance industry and the Dormant Commerce Clause.¹³³ Congress, however, retained the ability to preempt state law if it passes legislation indicating that it specifically applied to the business of insurance.¹³⁴ The passing of the MFA is explained in part because it came on the heels of Roosevelt's New Deal, at a time when there was a push from certain Congressmen to protect states' rights and regulatory authority in an effort to limit the mushrooming of federal oversight.¹³⁵

The final part of § 1012(b) of the MFA contains the insurance industry's controversial limited exemption from federal antitrust law:

That after June 30, 1948 . . . the Sherman Act, . . . the Clayton Act, and . . . the Federal Trade Commission Act, as amended, shall be applicable to the *business of*

¹³² *Id.* § 1012(a)–(b).

¹³³ Jones, *supra* note 44, at 387. The Dormant Commerce Clause is the principle that states cannot “unjustifiably . . . discriminate against or burden the interstate flow of articles of commerce. . . . ‘[D]iscrimination’ simply means differential treatment of in-state and out-of-state economic interests that benefits the former and burdens the latter.” *Or. Waste Sys., Inc. v. Dep’t of Env’tl. Quality*, 511 U.S. 93, 98 (1994).

¹³⁴ 15 U.S.C. § 1012(b).

¹³⁵ See Jones, *supra* note 44, at 396–97 (describing the influence of southern Congressmen with Congressmen from northeastern states—where the majority of insurance companies were located—banding together to pass the MFA in order to protect state regulatory authority).

*insurance to the extent that such business is not regulated by State law.*¹³⁶

The Act goes on to specify that the Sherman Act is always applicable to “any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.”¹³⁷ The purpose of the MFA federal antitrust exemption was to allow for cooperative rate-making efforts among insurance companies so that they could “underwrite risks in an informed and responsible way”¹³⁸ given the “unique difficulty of accurately pricing the insurance product.”¹³⁹ Although the federal antitrust exemption was only a “secondary purpose” of the MFA,¹⁴⁰ it created significant controversy as to its precise meaning and scope.

B. THE MEANING AND SCOPE OF THE FEDERAL ANTITRUST EXEMPTION OF THE MFA

The MFA’s exemption of “the business of insurance” from federal antitrust statutes to the extent that such business is regulated by state law and is not an act or agreement to boycott, intimidate or coerce is essentially a reverse preemption by Congress; that is, Congress preempted itself from regulating insurance unless it expressly states otherwise in legislation. As such, it is unusually deferential towards state regulation.¹⁴¹ By including the federal antitrust exemption in the MFA, Congress sought to bolster state regulation and increase state efforts to prevent exploitative practices in the industry, while reserving some federal antitrust enforcement with respect to acts involving boycotts, intimidation, coercion, and when states did not exercise regulatory authority over activities in the industry.¹⁴²

As a result of the MFA, Congress gave the opportunity to states to preempt federal antitrust laws by regulating antitrust in the business of

¹³⁶ See 15 U.S.C. §1012(b) (emphasis added).

¹³⁷ *Id.* § 1013(b).

¹³⁸ *Group Life & Health Ins. v. Royal Drug Co.*, 440 U.S. 205, 221 (1979).

¹³⁹ Mark F. Horning, *Antitrust Immunity for the Insurance Industry: Repeal, Safe Harbors, or Status Quo?*, 8 ANTITRUST 14, 14 (1994).

¹⁴⁰ *Royal Drug*, 440 U.S. at 219 n.18.

¹⁴¹ Jonathan R. Macey & Geoffrey P. Miller, *The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role In Insurance Regulation*, 68 N.Y.U. L. REV. 13, 20 (1993).

¹⁴² Joel B. Dirlam & Irwin M. Stelzer, *The Insurance Industry: A Case Study in the Workability of Regulated Competition*, 107 U. PA. L. REV. 199, 213–14 (1958).

insurance themselves if they were not doing so already. Thus, there was a push to get states to seize the opportunity to pass legislation during the three-year moratorium following the enactment of the MFA during which the Sherman, Clayton, and Federal Trade Commission Acts did not apply to insurance companies.¹⁴³ The NAIC produced model laws that states could adopt, including laws for the regulation of rates, an Unfair Trade Practices bill, and “Little Clayton” acts in an effort for states to adopt legislation that would regulate every part of insurance, and thereby preempt the Sherman, Clayton, and Federal Trade Commission Acts.¹⁴⁴ While groups such as the NAIC attempted to help states take advantage of the MFA federal antitrust exemption, the exemption’s applicability in certain situations was still uncertain. The complication was (and still is) that the MFA did not provide a definition of what constitutes the “business of insurance,” nor specify what it means for something to be regulated by state law, nor provide guidance on what amounted to a boycott. This resulted in a need for courts to interpret the statutory exemption. A survey of court decisions reveals the inexpedient nature of the exemption’s ambiguity.

1. Understanding the “Business of Insurance”

After Congress passed the MFA, courts struggled to determine the contours of the federal statutory exemption. The threshold question in any situation is whether something qualifies as the “business of insurance.” The initial trend among lower courts was to interpret this phrase broadly to include nearly every activity of an insurance company.¹⁴⁵ Eventually, however, this broad interpretation was narrowed when the Supreme Court made a distinction between general activities of insurance companies and activities that relate directly to “the business of insurance.”¹⁴⁶ The former are subject to federal law notwithstanding the exemption since the MFA “did not purport to make the States supreme in regulating all activities of insurance companies.”¹⁴⁷ That is, not all activities of insurance companies automatically fall within the exemption. Application of the phrase is thus

¹⁴³ Carlson, *supra* note 82, at 1137.

¹⁴⁴ *Id.*

¹⁴⁵ *See, e.g.,* Transnational Ins. Co. v. Rosenlund, 261 F. Supp. 12, 28 (D. Or. 1966) (indicating that the court had a duty to “liberally construe” the meaning of the business of insurance so that state regulation would fall under the MFA exemption).

¹⁴⁶ SEC. v. Nat’l Sec., Inc., 393 U.S. 453, 459–60 (1969).

¹⁴⁷ *Id.*

more concerned with the nature of the activity rather than the fact that it is an insurance company that is engaged in the activity.¹⁴⁸

Beginning in 1979, the Supreme Court adopted a more restrictive approach to the MFA antitrust exemption, which has continued to the present day. In *Group Life & Health Insurance Co. v. Royal Drug Co.*, the Court construed the meaning of “business of insurance” narrowly when it looked for three elements to determine if something qualifies as the business of insurance: (1) whether or not the activity involves the spreading and underwriting of a policyholder’s risk; (2) whether the activity is connected to the contractual relationship between the company and the insured; and (3) whether the activity is limited to entities within the insurance industry.¹⁴⁹

Three years later in *Union Labor Life Insurance Co. v. Pireno*, the Court refined and formalized these elements from *Royal Drug* into a tripartite test to determine if an activity should be considered as part of the business of insurance: “[F]irst, whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the industry.”¹⁵⁰ Each of the factors is relevant, though none of them is determinative.¹⁵¹ Some courts have held, however, that the first factor—transferring or spreading risk—is the primary characteristic of the business of insurance,¹⁵² and allow more flexibility in classifying an activity as constituting the business of insurance if this factor is present.¹⁵³

Under the first prong of the test—transferring or spreading of a policyholder’s risk—the Court has made a distinction between the spreading of risk and the reduction of risk.¹⁵⁴ Actions that do not involve an insurer assuming risk and distributing it among a group of similarly situated people fail to qualify as part of the business of insurance.¹⁵⁵ Thus,

¹⁴⁸ *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 781 (1993).

¹⁴⁹ *Royal Drug*, 440 U.S. at 214–15 (1979). Part of the Court’s reasoning for limiting the meaning of “business of insurance” was its recognition that “exemptions from the antitrust laws are to be narrowly construed.” *Id.* at 231.

¹⁵⁰ *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

¹⁵¹ *Id.*

¹⁵² *See Royal Drug*, 440 U.S. at 212–15.

¹⁵³ *See, e.g., Feinstein v. Nettleship Co. of Los Angeles*, 714 F.2d 928, 931 (9th Cir. 1983); *Klamath-Lake Pharm. Ass’n v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1285–87 (9th Cir. 1983).

¹⁵⁴ *Royal Drug*, 440 U.S. at 211–15.

¹⁵⁵ *Jerry, supra* note 1, at 422.

activities connected with products with no insurance risk, such as the searches and examinations involved with title insurance, do not qualify as constituting the business of insurance since title insurers assume little if any risk and such activities are often done by entities other than the insurance companies.¹⁵⁶ This factor, however, is not always easily discernible, and cannot be applied with extreme rigidity. For example, although reinsurance and retrocessional insurance agreements involve reducing the amount of risk and liability of insurance companies and perhaps would not qualify under the *Pireno* test, they are considered as part of the business of insurance.¹⁵⁷ Thus, one of the problems with the first factor is that it is subject to various interpretations and exceptions, and does not provide clear guidance on what should constitute the business of insurance.¹⁵⁸

Under the second prong of the test, the activity must be an integral part of the contractual relation between the insurer and insured in order to qualify as constituting the business of insurance. Activities that are not part of the insurer-insured contract, and which have only an indirect effect on it, are not part of the business of insurance.¹⁵⁹ Although this sounds straightforward, the involvement of agents and brokers with policyholders and insurers prevents definitive boundaries from being drawn.¹⁶⁰

The third prong of the test requires that the activity be limited to entities within the insurance industry. This prong, too, suffers from ambiguity. For instance, enactment of state law permitting insurance companies to enter into certain agreements with third party providers does not necessarily mean that the third prong of the test will be met.¹⁶¹ Insurance companies, therefore, must not only determine if the state

¹⁵⁶ See *Ticor Title Ins. Co. v. FTC*, 998 F.2d 1129, 1133–34 (3d Cir. 1993).

¹⁵⁷ *In re Ins. Antitrust Litig.*, 938 F.2d 919, 927 (9th Cir. 1991), *aff'd in part and rev'd in part on other grounds sub nom.* *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 784 (1993).

¹⁵⁸ *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 321 (D.C. Cir. 1982).

¹⁵⁹ *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129–32 (1982).

¹⁶⁰ While lower courts have occasionally applied the exemption to agents making market decisions and soliciting policyholders, *Arroyo-Melecio v. Puerto Rican Am. Ins. Co.*, 398 F.3d 56, 68 (1st Cir. 2005), the Supreme Court has not decided on certain issues, such as the fixing of agent commissions. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 224 n.32 (1979).

¹⁶¹ Michael A. Haskel, *Should Antitrust Principles Be Used to Assess Insurance Residual Market Mechanisms, Such As New York's Medical Malpractice Insurance Plan?*, 71 ALB. L. REV. 229, 290 (2008).

regulates the activity, but must ensure that it falls under the MFA exemption.¹⁶²

Thus, while the Supreme Court has identified three factors that should be considered when determining if an activity constitutes the business of insurance, the effectiveness of the *Pireno* test is questionable given the uncertainty that courts have in applying it. The factors when viewed separately can lead to contradictory conclusions, and it is unclear as to which factor should be given more weight when they conflict.¹⁶³ This muddies the understanding of when the MFA exemption should apply. In addition, application of the test does not always exempt activities that Congress intended to be exempt. For instance, activities such as cooperative-rate making and pooling of loss data were intended by Congress to fall within the MFA exemption, but would fail the *Pireno* test since they do not directly affect the insurer-policyholder relationship required by the second prong.¹⁶⁴ Thus, certain activities, even though they would fail the test, qualify as part of the business of insurance as exceptions due to Congressional intent.¹⁶⁵ The necessity of making such exceptions points to the inherently flawed structure of the test. Thus, while the *Pireno* test keeps the scope of the MFA exemption somewhat limited and provides some guidance on how to interpret the exemption, its effectiveness is plagued by ambiguity.¹⁶⁶

¹⁶² *Id.*

¹⁶³ Macey & Miller, *supra* note 141.

¹⁶⁴ See 91 CONG. REC. 1087-88 (1945) (statements of Reps. Hancock and Celler). Unfortunately the committee reports do not provide much guidance on what precisely the phrase “business of insurance” means. See, e.g., S. REP. NO. 79-20 (1945); H.R. REP. NO. 79-143. What is clear, however, is that “[i]t [was] not the intention of Congress in the enactment of [the MFA] to clothe the States with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision of the United States Supreme Court in the Southeastern Underwriters Association case.” H.R. REP. NO. 79-143, at 3 (1945). Prior to *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944), it was within the states’ authority to regulate the fixing of rates and sharing of data among insurers, which suggests that states were intended to continue regulating those activities. See Day, *supra* note 33.

¹⁶⁵ See, e.g., 91 CONG. REC. 1481 (statement of Sen. Ferguson).

¹⁶⁶ See Francis Achampong, *The McCarran-Ferguson Act and the Limited Insurance Antitrust Exemption: An Indefensible Aberration?*, 15 SETON HALL LEGIS. J. 141, 152 (1991). Although what activities constitute the “business of insurance” is not always clear, the Court has indicated that when a federal statute makes explicit reference to “insurance,” federal law does in fact preempt state law and state law is not protected under the MFA’s reverse preemption provision. See

2. Deciphering the Meaning of “to the Extent that such Business Is Not Regulated by State Law”

After it is determined whether an activity qualifies as constituting the “business of insurance,” the second requirement for an activity to fall under the MFA exemption is that it must be regulated by state law. The Supreme Court, however, has never defined what “to the extent that” means with respect to state regulation and what amount of state regulation is required before the exemption applies.¹⁶⁷ Even if there is state regulation in a certain area of insurance, it does not necessarily preclude application of federal antitrust laws.¹⁶⁸

The general rule that lower courts have adopted in determining whether sufficient state regulation exists is that a state is considered to regulate “the business of insurance within the meaning of [Section 2(b) of the MFA] when a State statute generally proscribes or permits or authorizes certain conduct on the part of the insurance companies.”¹⁶⁹ Therefore, the second requirement under the MFA is not difficult to meet. As long as the state has the *ability* to regulate a particular activity, that ability suffices even if the state does not actively exercise its regulatory authority.¹⁷⁰ For instance, the Eighth Circuit has held that the mere existence of a state statute granting authority to the state insurance commissioner to investigate trade practices was sufficient to invoke immunity under the MFA antitrust exemption even though the state merely retained “inchoate” regulation.¹⁷¹ Further, the exemption applies even if the state regulation is inadequate or ineffective.¹⁷² The Supreme Court, however, has noted that if state

Barnett Bank v. Nelson, 517 U.S. 25, 26 (1996) (holding that a 1916 federal statute that permitted national banks to sell insurance in small towns preempted a Florida law that prohibited such banks from selling most types of insurance, largely because the federal statute made an explicit reference to “insurance”).

¹⁶⁷ Anderson, *supra* note 127.

¹⁶⁸ *Id.* at 98.

¹⁶⁹ Cal. League of Indep. Ins. Producers v. Aetna Cas. & Sur. Co., 175 F. Supp. 857, 860 (N.D. Cal. 1959).

¹⁷⁰ Hovenkamp, *supra* note 28, at 637.

¹⁷¹ *In re Workers' Comp. Ins. Antitrust Litig.*, 867 F.2d 1552, 1558–60 (8th Cir. 1989).

¹⁷² See H.R. REP. NO. 102-1036, at 27 (1992) (stating that “[a] substantial number of decisions have addressed the sufficiency of State insurance regulation, and not one court appears to have held State regulation, in any form, insufficient to trigger the antitrust exemption”).

insurance regulations are a “mere pretense,” they may not be sufficient to qualify under the MFA antitrust exemption.¹⁷³

This low standard on what constitutes sufficient state regulation, although it remains the current standard, is contrary to Congressional intent, which was that federal antitrust laws would apply where states were not adequately regulating an activity.¹⁷⁴ The original intention and understanding behind the MFA exemption was that states must actively and affirmatively regulate the same areas covered by federal antitrust laws otherwise federal antitrust laws would be fully applicable.¹⁷⁵ Further, it was intended that state law must be “explicit” concerning the actions it was meant to regulate, and should be of a prohibitive nature rather than permitting a certain practice.¹⁷⁶ Thus, modern understanding and application of this part of the exemption restricts the applicability of federal antitrust laws much more than Congress intended.

3. The Meaning of Boycott, Coercion, or Intimidation from § 1013(b)

Lastly, in order for an activity to qualify under the MFA exemption, not only must it be within the “business of insurance” and regulated by state law, it also cannot constitute a boycott, coercion, or intimidation. The breadth of the boycott exception of the MFA as codified in 15 U.S.C. § 1013(b) is not evident from the wording. Courts that have considered the meaning of 15 U.S.C. § 1013(b) have usually had to address boycotts, though the principles used in considering boycotts can be applied to coercion and intimidation as well.¹⁷⁷

The Supreme Court first examined the meaning and scope of the boycott exception in § 1013(b) in *St. Paul Fire & Marine Insurance Co. v. Barry*.¹⁷⁸ While the Court considered various meanings of the term “boycott,” it did not settle upon a precise definition.¹⁷⁹ The Court did, however, hold that the language of the boycott exception is “broad and unqualified” and is not limited to actions against competing insurance

¹⁷³ *FTC v. Nat'l Cas. Co.*, 357 U.S. 560, 564 (1958).

¹⁷⁴ *See* 91 CONG. REC. 1444 (1945) (Senator Ferguson stating that federal “antitrust laws would still apply where states’ regulation was inadequate”).

¹⁷⁵ 91 CONG. REC. 1444 (1945) (statement of Sen. Murdock).

¹⁷⁶ *Id.* at 1481 (statement of Sen. Ferguson).

¹⁷⁷ A.B.A. SECTION OF ANTITRUST LAW, *INSURANCE ANTITRUST HANDBOOK* 28 n.119 (2d ed. 2006).

¹⁷⁸ 438 U.S. 531 (1978).

¹⁷⁹ *Id.* at 541–43.

companies or agents.¹⁸⁰ Thus, insurance companies can be subject to the Sherman Act not merely for boycotts against competitors, but also for boycotts against policyholders or other non-competitive third parties.¹⁸¹

In *Hartford Fire Insurance Co. v. California*, the Court highlighted the primary feature of a boycott when it stated that essentially a boycott consists of a concerted refusal to agree in one transaction in order get someone to accept the terms of an entirely different transaction.¹⁸² That is, “unrelated transactions are used as leverage to achieve the terms desired.”¹⁸³ Therefore, under *Hartford Fire*, there must be two *separate* transactions, one in which there is a refusal to deal in order to obtain acceptance in a second, different transaction. As such, price fixing is not necessarily a boycott under the MFA exception if it is merely a refusal to deal with another party based solely on the terms of a single transaction.¹⁸⁴ In general, the application of the Sherman Act under the boycott exception of § 1013(b) should be interpreted broadly, consistent with Congressional intent.¹⁸⁵ Even with this approach, however, “[e]xactly what types of activity fall within the forbidden category is . . . far from certain.”¹⁸⁶

¹⁸⁰ *Id.* at 550.

¹⁸¹ *Id.* at 552.

¹⁸² *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 806 (1993).

¹⁸³ *Id.* at 803.

¹⁸⁴ *See id.* at 802; *Thomsen v. Sun Co., Inc.*, 498 F. Supp. 1109, 1111–12 (E.D. Pa. 1980).

¹⁸⁵ *See* Senator Mahoney’s statement that “every effective combination or agreement to carry out a program against the public interest...would be prohibited by [§ 1013(b)].” 91 CONG. REC. 1486 (1945).

¹⁸⁶ *Northwest Wholesale Stationers, Inc. v. Pac. Stationers & Printing Co.*, 472 U.S. 284, 294 (1985). It is beyond the scope of this Article to comprehensively discuss each insurance activity and how courts have analyzed them under the MFA exemption. For a broad discussion of various insurance activities and their legality under the MFA exemption, see generally INSURANCE ANTITRUST HANDBOOK, *supra* note 177.

III. PUTTING THE SISYPHEAN TASK TO REST: A HYBRID APPROACH

So the point is, is there something that needs to be fixed?¹⁸⁷
~Michael McRaith

The MFA, though perhaps less than a model of clarity, is significant legislation for a variety of reasons. One major reason is the importance of the subject matter it regulates: the insurance industry. Insurance plays an integral role in modern American society by protecting families, businesses, and individuals from unexpected economic burdens. In addition, the American economy relies to a great extent on the insurance industry. In 2002, there were over 5000 insurance companies which had combined revenues of \$1.2 trillion in the United States.¹⁸⁸ More current figures indicate that the premium dollars of insurance companies comprise approximately 10% of the American economy.¹⁸⁹ An average American family easily spends over \$7000 each year to meet all of its insurance needs, including auto, home, life, and health insurance.¹⁹⁰ Insurance, however, is currently the last major industry in the United States that is regulated by the states.¹⁹¹ In fact, all other major industrialized nations regulate insurance on the national level.¹⁹² It is beyond the scope of this Article, however, to discuss the arguments for or against continued state

¹⁸⁷ *Hearing on Statutory Immunities and Exemptions: The McCarran-Ferguson Act Before the Antitrust Modernization Commission* 53 (Oct. 18, 2006) [hereinafter *Hearing on Statutory Immunities and Exemptions*], available at <http://www.abanet.org/antitrust/at-committees/at-exemc/pdf/main-exemptions/mccarran/10.18.06.pdf> (statement of Michael McRaith, Chairman of the Broker Activities Task Force of the NAIC).

¹⁸⁸ *State Regulation of Insurance Under the McCarran-Ferguson Act: Hearing Before the S. Comm. on the Judiciary*, 109th Cong. 8 (June 20, 2006) [hereinafter *Hearing Before the S. Comm. on the Judiciary*], available at <http://www.abanet.org/antitrust/at-committees/at-exemc/main-exemptions/mccarran-ferguson.shtml> (testimony of Michael McRaith, Chairman of the Broker Activities Task Force of the NAIC).

¹⁸⁹ *Id.* (testimony of Elinor Hoffmann, Assistant Attorney General of New York).

¹⁹⁰ *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, available at <http://www.abanet.org/antitrust/at-committees/at-exemc/main-exemptions/mccarran-ferguson.shtml> (written testimony of Michael McRaith, Chairman of the Broker Activities Task Force of the NAIC).

¹⁹¹ Jones, *supra* note 44, at 346.

¹⁹² *Id.*

regulation and taxation of the insurance industry in general.¹⁹³ It is limited to an analysis of the interplay between federal antitrust laws and state regulation as currently embodied within the MFA antitrust exemption.

The repeated questioning of the MFA antitrust exemption, and in particular with the Insurance Industry Competition Act of 2007 and 2009, brings further reason to pause and consider what should be done concerning the MFA exemption, whether to leave it in place without any change, repeal it entirely, or modify it. Groups have answered these questions in various ways since the enactment of the MFA. It is generally agreed that the purpose of antitrust laws is to promote the welfare and best interests of consumers.¹⁹⁴ It is also widely held that entirely unregulated competition in the insurance industry is not an alternative.¹⁹⁵ Thus, the disagreement is over what exactly the best interests of consumers are, who should ensure that they are protected, and how that is best accomplished.

A. NO CHANGE: THE PATH OF LEAST RESISTANCE

Of course, the easiest approach to the MFA antitrust exemption is to leave it entirely intact with no modifications. Proponents of leaving the MFA antitrust exemption in place try to justify it on several grounds. First, proponents of preserving the MFA exemption argue that the exemption is necessary because insurance is a unique product in that it is essentially a promise to pay a future obligation upon the occurrence of a contingent future event.¹⁹⁶ Because these costs are purportedly far more unpredictable

¹⁹³ See National Insurance Act of 2006, S. 2509, 109th Cong. § 2 (2006) (for a proposal to allow insurance companies to opt out of state regulation, apply for a federal charter, and be subject to federal regulation).

¹⁹⁴ See, e.g., *Hearing Before the S. Comm. on the Judiciary*, *supra* note 188, at 4 (testimony of Elinor Hoffman); *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, at 8 (written testimony of Michael McRaith) (indicating that the main priority “is to protect consumers”).

¹⁹⁵ E.g., Dirlam & Stelzer, *supra* note 142, at 214. The MFA is, of course, based not just on the conclusion that continued regulation of insurance *by the states* is in the best interests of consumers, but also on the assumption that regulation of insurance *in general* is necessary. Various reasons have been given on why government regulation is necessary: (1) to ensure that insurance companies remain solvent; (2) to ensure reasonable rates; and (3) to monitor the fairness of policy terms. Carlson, *supra* note 82, at 1138–39.

¹⁹⁶ *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, at 17 (statement of Julie Gackenbach, Representative, National Association of the Mutual Insurance Companies).

than other products and services,¹⁹⁷ in order for insurers to set accurate premiums and remain solvent they must accurately estimate future costs, which requires accumulating a large amount of claims data—something few companies would be able to develop because of cost.¹⁹⁸

Proponents of the exemption argue that repealing it would prevent certain pro-competitive activities such as loss-data sharing and rate-making from continuing,¹⁹⁹ which could threaten the solvency of companies.²⁰⁰ The claim is that certain collaborative activities allow companies to offer more affordable products by reducing costs connected to calculating adequate rates.²⁰¹ This has the further alleged benefit of helping to protect all companies from mispriced products and ultimately from insolvency.²⁰² In addition, reducing costs connected with determining adequate prices is alleged to help smaller companies compete.²⁰³ As a result, consumers have more companies from which to buy insurance and are protected from companies becoming insolvent based on the prevention of rates that are too low.

This argument, however, is misleading. The reporting of historic data on past losses by insurance companies and the pooling of such information by rating associations has long been recognized to have pro-competitive benefits and would withstand Sherman Act scrutiny even in the absence of the MFA exemption.²⁰⁴ Proponents of the exemption are accurate in claiming that other elements of rate-making would be per se illegal under the Sherman Act, or at the very least would be questionable under a rule of reason analysis. For instance, projections of future trends in pricing or costs (“trending”); the development of “end rates” that would be

¹⁹⁷ Horning, *supra* note 139, at 14.

¹⁹⁸ *Id.*; see also *Hearing Before the S. Comm. on the Judiciary*, *supra* note 188, at 152 (testimony of Kevin Thompson, Senior Vice President, Insurance Services Office) (indicating that in 2005 it cost over \$11 million for the Insurance Services Office to provide advisory prospective loss costs for one type of insurance product).

¹⁹⁹ Achampong, *supra* note 166, at 155. It is not possible to consider all of the alleged pro-competitive activities in this Article; discussion, therefore, has been limited to the activity of elements of rate-making.

²⁰⁰ *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, at 37 (statement of Michael McRaith).

²⁰¹ See Achampong, *supra* note 166, at 155.

²⁰² *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, at 37 (statement of Michael McRaith).

²⁰³ *Id.* at 15–16 (statement of Julie Gackenbach).

²⁰⁴ Horning, *supra* note 139, at 16–17.

sufficient to cover all prospective loss costs, expenses in underwriting the risk, and factoring in sufficient profit; and the collaborative creation of “loss development” information that estimates ultimate costs of reported but claims not yet paid would not likely be permitted without the MFA exemption.²⁰⁵

Nevertheless, the necessity of end rates that factor in an expense and profit component that is not connected to an individual company's particular expenses profits is dubious in the first place. Finalization of pricing would ideally be determined by particular insurance companies in order to avoid exaggerated expenses or profits because there is virtually an unlimited amount of discretion in determining how many years of data should be considered, how to average such data, and how much weight should be given to different averages.²⁰⁶ In addition, prospective loss costs, trending, and loss development could be supplied by independent actuarial companies rather than rating associations. This would not necessarily result in higher premiums for consumers. For instance, the State of California repealed its antitrust exemption for collective rate-making activities with respect to automobile insurance.²⁰⁷ In the ten-year period following the repeal of the state antitrust exemption, rates lowered significantly, dropping California from the third costliest state in the nation for automobile insurance to the twentieth.²⁰⁸ Further, the solvency of companies is not a significant factor as evidenced by the fact that since 1950, only 0.66 of 1% of insurers have become insolvent.²⁰⁹

Second, proponents of retaining the exemption as it currently exists argue that it has worked well since its enactment by ensuring a competitive market, and that state monitoring of anticompetitive, unfair, and deceptive trade practices has been effective.²¹⁰ This position, however, is questionable. Although all fifty states plus the District of Columbia have some type of state antitrust statute,²¹¹ there are a number of states that have exemptions for insurance activities, which means that even if an antitrust

²⁰⁵ ABA SECTION OF ANTITRUST, *supra* note 177, at 47–50.

²⁰⁶ *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, at 50 (statement of Jay Angoff).

²⁰⁷ *Hearing Before the S. Comm. on the Judiciary*, note 188, at 23 (statement of Bob Hunter, Insurance Director, Consumer Federation of America).

²⁰⁸ *Id.*

²⁰⁹ *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, at 9 (statement of Michael McRaith).

²¹⁰ *Hearing Before the S. Comm. on the Judiciary*, *supra* note 188, at 10–11 (statement of Michael McRaith).

²¹¹ ABA SECTION OF ANTITRUST, *supra* note 177, at 35.

violation occurred, many of these states would not bring an action against the companies.²¹² In states that do not have broad exemptions, the antitrust penalties are not as severe as federal antitrust penalties, making them less of a deterrent for illegal behavior.²¹³ Further, there is no private right of action in most states for unfair insurance trade practices.²¹⁴ Even in a situation such as the State of New York's recent investigation of various companies for bid-rigging and customer allocation that resulted in over \$3 billion in settlements for restitution and penalties,²¹⁵ the settlements did not cover activities that were applicable on a nation-wide basis; they were limited to only the few states that joined in the investigation.²¹⁶ Therefore, state antitrust regulation does not appear to be as effective as proponents of the exemption claim.

Of course, for purposes of the MFA exemption, the question is not merely whether increased federal antitrust enforcement would be more effective in deterring or punishing anticompetitive behavior. Even certain state officials have recognized that increased enforcement of federal antitrust laws would be more effective at protecting the best interests of consumers.²¹⁷ This alone argues for modification of the exemption. But for those who insist on continued near-exclusive state enforcement of antitrust regulation, the question is also whether the current understanding and application of the MFA exemption correlate to the original intention of Congress in crafting it. The original understanding and intention of the exemption is that there would be *active* state regulation, and without such regulation, the Sherman, Clayton, and Federal Trade Commission Acts would be applicable.²¹⁸ Unfortunately, the current understanding and application of the MFA exemption require only a minimal showing of state oversight (the mere ability to exercise authority) in order to preempt federal

²¹² Donald C. Klawiter, Chair, Section of Antitrust Law for the American Bar Association, Letter to the Honorable Arlen Specter, Chairman, Senate Committee on the Judiciary, July 27, 2006 (on file with ABA, *available at* http://www.abanet.org/poladv/letters/antitrust/060728letter_1-wa_2604707_2.pdf).

²¹³ *Id.*

²¹⁴ *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, at 71 (statement of Jay Angoff).

²¹⁵ *Hearing Before the S. Comm. on the Judiciary*, *supra* note 188 (testimony of Elinor Hoffman).

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *See* 91 Cong. Rec. 1481 (1945) (statement of Sen. Murdock).

antitrust laws,²¹⁹ thereby granting a level of latitude to the industry it was not meant to have.

Proponents of retaining the exemption also argue that repeal would result in uncertainty and frequent, costly litigation, subjecting the industry to varying interpretations by a large number of judges.²²⁰ While this argument raises a valid point, there is no indication that litigation as a result of increased application of federal antitrust statutes would be substantially more than the number of lawsuits that have been needed and continue to be needed to determine the meaning of the MFA exemption in particular circumstances.

Therefore, while proponents of retaining the status quo try to meet the Antitrust Modernization Commission's call to justify the insurance industry's exemption under the MFA,²²¹ they have not satisfied their burden of explaining its continued necessity.

B. MODIFYING THE EXEMPTION: OPENING THE DOOR OF POSSIBILITY

Those who argue for repeal of the MFA antitrust exemption for the insurance industry do so based on a number of reasons. The current trend is to question and remove regulatory immunities.²²² Further, some claim that the exemption immunizes activities that have significant anti-competitive effects, while not immunizing others that are only questionably anticompetitive. For example, one scholar has pointed out the irony that certain anticompetitive horizontal restraints such as price-fixing agreements are immunized, but certain vertical agreements in which insurers engage in peer review of providers of prescription drugs are held to be outside the

²¹⁹ See *supra* Part II.B.ii.

²²⁰ See, e.g., *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, at 53, 78–79 (statements of Michael McRaith).

²²¹ See *supra* note 27 and accompanying text.

²²² See J. David Cummins, *Property-Liability Insurance Price Deregulation: The Last Bastion?* 1, in *DEREGULATING PROPERTY-LIABILITY INSURANCE: RESTORING COMPETITION AND INCREASING MARKET EFFICIENCY* (J. David Cummins ed., 2002) (noting that in the last two decades, various industries, such as airlines, trucking, railroads, telecommunications, and banking, have experienced deregulation with regard to prices and entry and exit restrictions); Hovenkamp, *supra* note 28, at 630–31 (stating that antitrust laws are now applicable to industries such as telecommunications which previously had enjoyed significant “regulatory immunity”).

“business of insurance.”²²³ Another argument is that repealing the exemption would result in increased competition,²²⁴ and would collectively save insurance consumers an estimated \$45 billion per year.²²⁵ It has also been asserted that repealing the exemption would make antitrust enforcement uniform, which would benefit consumers *and* insurance companies by removing inefficient multiple proceedings under disparate laws, and thereby limiting the possibility of inconsistent results.²²⁶

Proponents of repealing the exemption further argue that the exemption is unnecessary in light of alternatives that can better protect the best interests of consumers. One alternative is to repeal the exemption, but allow certain insurance activities to still be exempt from federal antitrust laws under the state action doctrine.²²⁷ The state action doctrine, which originated in *Parker v. Brown*, provides immunity to private parties if their conduct is authorized and regulated by the state.²²⁸ In order for the state action doctrine to apply, however, there must be a *clear articulation* in state policy concerning the activity, and the state must *actively supervise* the policy.²²⁹ This is a higher standard of regulation than that required by the current interpretation of the MFA exemption, and seems more in line with the original Congressional intent in passing the MFA. In fact, § 1012(b) of the MFA (“to the extent that such business is not regulated by state law”) is arguably a codification of the state action doctrine from *Parker*.²³⁰ President Roosevelt espoused this position when he wrote to Senator Radcliffe that “there is no valid reason for giving any special exemption from the antitrust laws to the business of insurance. . . . The antitrust laws do not conflict with affirmative regulation of insurance by the States.”²³¹

The state action doctrine clearly contains a higher standard of supervision by the state than the MFA does and is arguably more in line with the original intention and understanding behind the MFA exemption. This approach would leave intact the federalist purpose behind the MFA,

²²³ See, e.g., Hovenkamp, *supra* note 28, at 636–37.

²²⁴ *Hearing Before the S. Comm. on the Judiciary*, *supra* note 188 (statement of Donald Klawiter) (expressing the position of the American Bar Association).

²²⁵ *Id.* (statement of J. Robert Hunter).

²²⁶ *Id.* (statement of Elinor R. Hoffman).

²²⁷ Hovenkamp, *supra* note 28, at 638–39.

²²⁸ 317 U.S. 341 (1943).

²²⁹ *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 633 (1992); *Ca. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

²³⁰ Weller, *supra* note 111, at 615.

²³¹ 91 CONG. REC. 482 (1945).

and alleviate fears that encroaching on state regulation of antitrust in insurance is a step towards federal regulation of insurance in general.²³² Relying on the state action doctrine alone, however, might result in insurance companies demanding that state insurance codes be changed in order to clearly meet the requirements of state action analysis, and it would also result in a need for litigation in order to determine the scope of the doctrine since it is largely undeveloped in the insurance context due to the current application and understanding of the MFA exemption. Further, many states have already chosen *not* to assume an active and affirmative stance to antitrust regulation in the insurance industry.²³³ Thus, repeal of the exemption and reliance on the state action doctrine alone would result in a continued disparate approach to antitrust enforcement. Full repeal of the exemption and relying on the state action doctrine alone, therefore, seems unwise in light of the uncertainty and lack of uniformity that would result. Nevertheless, reliance on the state action doctrine *in addition to* exempt safe harbors would help remedy any drawbacks to relying on the state action doctrine alone.

Thus, in addition to the state action doctrine, proponents of repealing the MFA exemption have also proffered safe harbors as another alternative to the MFA exemption. It is significant that the NAIC prior to the enactment of the MFA proposed a list of seven safe harbor activities that it viewed as sufficient for the insurance industry; it never asked for a blanket exemption from federal antitrust laws.²³⁴ Proponents of repeal argue that express safe harbors would prevent or at least lessen litigation to determine what activities would be acceptable in the aftermath of full repeal of the exemption since they would be expressly permitted or not, and they would permit recognized pro-competitive activities beneficial to the industry and consumers that require a certain amount of collaboration among companies.²³⁵

Those who oppose repeal of the MFA exemption, and therefore oppose the implementation of safe harbors, argue that safe harbors do not

²³² Macey & Miller, *supra* note 141, at 63.

²³³ See Klawiter, *supra* note 243 (indicating that nineteen states have express antitrust law exemptions for the insurance industry in their laws).

²³⁴ 90 CONG. REC. A4406 (1944). The NAIC's intent with its proposal to Congress prior to the passing of the MFA was to "preserve[e] state regulation and at the same time not emasculat[e] the federal anti-trust laws." Weller, *supra* note 111, at 593 (quoting 1945 NAIC Proc. 156, 159–60).

²³⁵ Section of Antitrust Law, American Bar Association, Comments to the Antitrust Modernization Commission Regarding the McCarran-Ferguson Act 2 (April 2006).

provide the clear protection to insurance companies of legitimate collaborative, pro-competitive activities, but would still require judicial interpretation of the safe harbors if the language is too ambiguous.²³⁶ In addition, it is argued that it might be difficult to compile a comprehensive list of all activities that should be explicitly exempted.²³⁷

The safe harbor approach, however, seems to reach a middle ground between those who favor complete repeal of the MFA exemption and those who wish to preserve it in its present form. If formulated properly, express safe harbors would protect desirable pro-competitive, collaborative activities such as compiling and sharing of historical and prospective loss cost data, and standardized policy forms. This would prevent any sort of chilling effect on activities beneficial to the best interests of consumers by providing insurance companies with confidence in the legality of the activities. At the same time, it would not permit insurance companies to raise illegitimate defenses to challenged activities. Ultimately it would help provide clarity to all parties involved, and would further uniformity in antitrust enforcement. Nevertheless, it would require significant deliberation on what activities should be expressly exempted and how the safe harbor exemptions should be worded. A reasonable approach to the safe harbors would be to adopt the seven activities specified by the NAIC during the deliberation of the MFA.

C. THE INSURANCE INDUSTRY COMPETITION ACTS OF 2007 AND 2009

The latest proposed alternative to the MFA exemption was the Insurance Industry Competition Act of 2007,²³⁸ now the Insurance Industry Competition Act of 2009.²³⁹ The express purpose of the Insurance Industry Competition Act of 2009, borrowing from its 2007 predecessor, is “[t]o further competition in the insurance industry.”²⁴⁰ It proposes to do this by repealing the MFA exemption and making the Sherman, Clayton, and Federal Trade Commission Acts applicable to the insurance industry by amending the MFA (§ 1012(b)) from: “That after June 30, 1948 . . . the

²³⁶ *Hearing on Statutory Immunities and Exemptions*, *supra* note 187, at 78 (statement of Michael McRaith) (commenting on the ambiguity of the wording of the safe harbors put forth by the American Bar Association).

²³⁷ *See id.* at 60 (statement of Julie Gackenbach).

²³⁸ S. 618, 110th Cong. (2007); H.R. 1081, 110th Cong. (2007).

²³⁹ H.R. 1583, 111th Cong. (2009).

²⁴⁰ *Id.*

Sherman Act, . . . the Clayton Act, and . . . the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law²⁴¹ to:

That after June 30, 1948 . . . the Sherman Act, . . . the Clayton Act, and . . . the Federal Trade Commission Act, as amended, *as it relates to unfair methods of competition*, shall be applicable to the business of insurance. *The Federal Trade Commission Act, as it relates to areas other than unfair methods of competition, shall be applicable to the business of insurance* to the extent that such business is not regulated by State law.²⁴²

It also proposes to do away with the boycott exemption in § 1013 by striking § 1013 altogether.²⁴³ Further, it proposes that authority be given to the Department of Justice and the Federal Trade Commission to issue joint statements concerning their policies on joint activities in the insurance industry.²⁴⁴

The Insurance Industry Competition Act of 2009, therefore, would make the Sherman, Clayton, and Federal Trade Commission Acts applicable to the insurance industry in virtually full force. It proposes to do so, however, without providing any safe harbors for the insurance industry. As such, it is an extreme form of legislation in that it would subject the insurance industry to full federal scrutiny of its practices, though tempered by possible exceptions that could arise from the state action doctrine.

The Act's approach in trying to accomplish its express purpose of furthering competition in the insurance industry, therefore, seems to suffer from overzealousness. The Act would subject insurance companies to ambiguity with respect to nearly every collaborative practice, although this would put them in no worse position than companies in nearly every other industry. This seems harmful to possible pro-competitive practices in that insurance companies would be hesitant to engage in them due to their unknown legality. It also seems unnecessary given that such a chilling effect could easily be avoided by providing express safe harbors. As such, the Act is inadvisable in its proposed form.

²⁴¹ 15 U.S.C. §§ 1012(a)–(b) (2006).

²⁴² *Supra* note 188 (proposed changes of the bill are in italics).

²⁴³ *Id.*

²⁴⁴ *Id.*

Nevertheless, the Act should not be dismissed entirely. Its proposal suggests that the current application and understanding of the MFA have strayed from Congress's original intent and purpose. In addition, it provides an element that is worthy of consideration in any discussion of the MFA exemption and how it should be handled, whether preserving, repealing, or modifying it in some way. It suggests a heightened role of oversight by the Department of Justice and the Federal Trade Commission in a concrete way. The Act would authorize the Department of Justice and the Federal Trade Commission to issue joint statements regarding joint activities in the insurance industry, which is reasonable if any sort of accommodation with respect to federal antitrust laws is made;²⁴⁵ companies would also likely be able to obtain advisory opinions from the Department and the Commission. If such authorization is exercised, it could help provide clarity on what is acceptable under federal antitrust law. Such statements would be helpful in providing guidance to the insurance industry on what activities are acceptable, regardless of whether the MFA exemption is repealed or left in place. Further, the original federalist purpose behind the MFA would be preserved to a certain extent. States that "provide the same exemptions as the federal government or follow federal precedent would be able to pursue antitrust actions against insurance companies under their state law."²⁴⁶

Thus, while the Act is not an ideal form of legislation, it introduces an element—statements or advisory opinions from federal agencies—that should be seriously considered. New legislation with similar provisions would also further Congress's original intent of having active antitrust regulation. If express safe harbors are added to the Insurance Industry Competition Act of 2009 or to a similar bill, it would essentially preserve the same pro-competitive activities currently allowed under the MFA exemption, give clarity on which specific activities are legal, and also provide a greater deterrent to any activities that are not in the best interests of consumers.

²⁴⁵ See Dirlam & Stelzer, *supra* note 142, at 215.

²⁴⁶ Klawiter, *supra* note 212. It is possible that greater applicability of federal antitrust laws to the insurance industry would also encourage greater private antitrust enforcement. That is, victims of antitrust violations would likely be more inclined to bring private antitrust cases due to potentially larger damages under federal antitrust law. This could be a positive result given evidence showing that private antitrust enforcement has a greater deterrent effect than enforcement by the Department of Justice. See generally Robert H. Lande & Joshua P. Davis, *Benefits from Private Antitrust Enforcement: An Analysis of Forty Cases*, 42 U.S.F. L. REV. 879 (2008).

CONCLUSION

This Article has provided a broad overview of the history of antitrust regulation of the insurance industry in the United States and a snapshot of its present state today. Since its enactment, the necessity and advisability of the MFA federal antitrust exemption has been consistently questioned. This consistent questioning of the exemption places the burden on its proponents to justify its relevance and effectiveness in protecting the best interests of consumers. Those who favor fully retaining the exemption in its present form provide reasonable concerns about the exemption's repeal or modification. Such concerns, however, do not provide adequate justification for the exemption when any benefit that the exemption provides can also be accomplished more effectively by express safe harbors, combined with advisory statements from the Department of Justice and Federal Trade Commission. As such, the Insurance Industry Competition Act of 2009 should be given serious consideration, though modified, in order to provide express safe harbors for pro-competitive activities. If the current bill is modified, or a similar bill proposed and adopted, Congress's self-inflicted Sisyphean task of seeking to protect the best interests of consumers would finally come to a desirable end.

BOOK REVIEW: THE LANGUAGE OF *LIVES*

Jill C. Anderson

For outsiders, perhaps it is the historian's relationship to the particular that epitomizes the discipline and frames our expectations as readers. To mine boundless archival sources for shards of a story, and to fashion those odd individual shapes into a coherent one among many possible narratives -- this speaks to an intellectual calm beyond the reach of most of us. Delivering on this expectation, Timothy Alborn's *Regulated Lives: Life Insurance and British Society, 1800-1912* tells a story of a little-understood institution's path into modernity, assembled of well-chosen detail on a foundation of comprehensive research.¹ Importantly, Alborn's excavation of Victorian life insurance fills gaps in business history. But its most surprising feature, one that readers glimpse just a few pages into the book, is the sweep of its conceptual departure point: the meaning of life. And not just one meaning, but four distinct conceptualizations of modern life -- as he terms them: the sympathetic, the numbered, the medicalized, and the commodified life² -- that Alborn argues evolved during the Victorian era and are uniquely merged in the institution of life insurance.³

A preliminary project of Alborn's book is to name and strain out these life-dimensions, in something like the way a prism takes in white light and separates it into a spectrum.⁴ He then shows how those bands came to be braided together, each one developing alongside and in tension with the others as they shaped Victorian life insurance and in turn were

· Visiting Professor of Law, University of Connecticut School of Law. I am grateful to the University of Connecticut's Insurance Law Center and Pat McCoy in particular for the opportunity to share perspectives on *Regulated Lives* with Sharon Murphy, Geoff Clark, and Tom Baker, with Peter Kochenburger moderating the discussion with his usual expertise and generosity. I owe much to Susan Schmeiser for teaching me how to read more smartly and sensitively. Finally, many thanks are due Tim Alborn for giving us this important, lovingly crafted book to convene around and celebrate.

¹ TIMOTHY ALBORN, *REGULATED LIVES: LIFE INSURANCE AND BRITISH SOCIETY, 1800-1914* (2008).

² *Id.* at 7.

³ *Id.* at 7-13.

⁴ This metaphor is borrowed from the author, who uses it to depict the fragmentary nature of modernity and its resistance to being folded into grand narrative without stranding or jettisoning facts that do not follow its plot. *Id.* at 296-97.

shaped by that institution as a producer of culture. As this express project of the book unfolds, a parallel, subtler plot of sorts develops at a linguistic level. In breaking out a typology of “lives,” the author calls into service a figure of speech that is ubiquitous in life insurance and in insurance in general: *metonymy*, the non-literal use of a word to represent an associated concept.⁵ “Lives,” in the parlance of insurance, is nearly always shorthand for something associated with lives: e.g., policy holders, policies, bodies, medical subjects, breadwinners, health states, predictions of longevity, and, of course, deaths. In *Regulated Lives*, Alborn’s multiple meanings of “life” both complicate and organize the underlying, undifferentiated metonym in ways that mirror certain strange and intriguing paradoxes inherent in life insurance.

Among the fourfold typology of “lives,” we encounter first the *sympathetic life*. Within this meaning, it is one’s contemplation of dying and leaving others destitute that is essential to the demand for life insurance,⁶ and insurers aimed to generate a “sympathetic exchange” with the public.⁷ The more impersonal *numbered life* was the province of the actuary, who tabulated life expectancies and organized them into mortality tables. This was the relatively easy task, at least as it reflected mortality for “healthy males,” but actuarial science was considerably more challenged to convert mortality statistics into meaningful risk categories. While actuaries were zooming out from persons to numbers to norms (sometimes very far out, as when seeking in vain an ancient “law of mortality” in the early nineteenth century),⁸ medical examiners were focusing closely on individual bodies. In a break from therapeutic or investigative applications of medicine, they applied the latest science to scrutinize *medicalized lives* for signs of defect that would render them uninsurable.⁹ And finally, the development of these conceptual categories all took place within a

⁵ See MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY 782 (11th ed. 2003). Examples of metonymy include “the crown” to represent a monarchy or “Hollywood” as a stand-in for the American entertainment industry. See *id.*

⁶ I mean here to refer to the demand for life insurance as an income substitute for the breadwinner-insured, as opposed to the class of debtor-insureds for whom life insurance was a condition of credit. See ALBORN, *supra* note 1, at 136-37.

⁷ *Id.* at 156 (citing ELAINE HADLEY, MELODRAMATIC TACTICS: THEATRICALIZED DISSENT IN THE ENGLISH MARKETPLACE, 1800-1885 30-31 (1995)).

⁸ ALBORN, *supra* note 1, at 124.

⁹ *Id.* at 205-51.

rationalizing market that equated mortality with money, giving us the *commodified life*.¹⁰

Anyone who doubts that these categories work beyond characterizing British life insurance should consider the recent public controversy over guidelines for breast cancer screening through mammography.¹¹ When a federally appointed medical advisory panel recommended delaying routine mammograms, citing a low likelihood that more aggressive screening would save lives in significant number,¹² the ensuing public debate echoed the tensions that Alborn has identified, in another life-and-death context. Both might be characterized as sympathy meets medicine meets math meets money.¹³

These four conceptualizations of life might appear to be interrelated as natural allies or rivals with their tensions following predictable plotlines. Sympathy, for example, stands apart as humanizing life insurance, defining certain essential relations that must hold between the insurer and the insured (can the policyholder trust the insurer to be a surrogate breadwinner?) and between that insured and his dependants (is the policyholder sensitive enough to their plight to pay premiums for their benefit alone?). Symbolized in literature by the Victorian deathbed,¹⁴ the perspective of sympathy recognizes the policyholder as an individual with complex relationships and responsibilities, in contrast to the other three more objectifying dimensions.¹⁵ And just as the deathbed motif has given way in to its contemporary equivalent, the hospital bed, we might anticipate a story of life insurance's "softer feelings" losing ground to the cold rationality of the mortality table or the scrutiny of the medical examination table.

A more complex dynamic emerges in *Regulated Lives*, however, notably in the chapter on the gatekeeping practices, by which insurers excluded or charged higher premiums based on risk. Insurers in the early to mid-nineteenth century screened applicants based on interviews, referrals, and a proposal form.¹⁶ Early gatekeeping was largely

¹⁰ *Id.* at 181.

¹¹ TOM BAKER, *INSURANCE LAW AND POLICY* 158-59 (2d. ed. 2008).

¹² *Id.*

¹³ For commentary on the controversy over mammograms see, e.g., Kevin Sack, *Screening Debate Reveals Culture Clash in Medicine*, N.Y. Times, Nov. 20, 2009, at A1.

¹⁴ ALBORN, *supra* note 1, at 149.

¹⁵ See ALBORN, *supra* note 1, at 156.

¹⁶ *Id.* at 232.

interpersonal, intuitive, and trust-based; in other words, “intimate but unreliable.”¹⁷ With a widening market, a burgeoning field of diagnostic medicine, and growing mistrust of the truthfulness of applicants, insurers by 1900 had come to rely chiefly on medical examinations to police adverse selection.¹⁸ A triumph for the medicalized conception of life? Not so fast. The indignity of the medical exam made it unpopular with consumers and sales agents alike.¹⁹ Products that dispensed with the exam gained favor in the early 1900s, striking a blow for sympathy as mediated through the market.

Another surprising relationship emerges in the tension between numbered and medicalized conceptions of life, two dimensions of science that appear from a distance to reinforce each other. Starting from the baseline of confident mortality tables, it seemed to insurers that diagnostic medicine could be brought into the service of actuarial science. Medicine held the prospect of refining the sweepingly general mortality statistics by introducing meaningful risk categories. Once having identified the markers of mortality, the medical gaze could be trained on the individual body in order to screen out or rate up “inferior lives,” or so insurers hoped.

But bodies do not give up “Fate’s secrets”²⁰ easily, we learn, either individually or in the aggregate. This was true in two senses. First, being “poked and prodded” made people uneasy enough when undertaken by an attending physician for the purpose of treatment; swapping the attendant with the “medical police”²¹ and replacing therapy with evaluation only made the scrutiny more objectionable. Second, many features that were deemed abnormal (e.g., a lanky build,²² albumin in the urine,²³ etc.) turned out to be of little use as predictors of mortality. It made sense that insurers screened for lung problems in a period of rampant tuberculosis, but even some of this attention was misplaced, as when insurers took chest circumference and breathing capacity as a measure of respiratory health.²⁴ Much of Victorian gatekeeping of the medicalized life calls to mind the saw of “looking for one’s lost keys under the lamppost”: insurers tended to collect information on deviance that was easy to detect (e.g., epilepsy,

¹⁷ *Id.* at 241.

¹⁸ *Id.* at 245.

¹⁹ *Id.*

²⁰ *Id.* at 265.

²¹ *Id.* at 253.

²² *Id.* at 263.

²³ *Id.* at 267.

²⁴ *Id.* at 263.

insanity, physiognomic judgments), with disappointing results for risk classification.²⁵ But in the end – and here is the twist wrought by the numbered conception of life – there was always the law of large numbers. Medicine might take pains to sniff out pathology in applicants, but as numbered lives, those applicants were often normal enough to be insurable.²⁶ Doctors had arrived at the actuaries' starting point: "the future could be predicted only for aggregate populations and never for individuals."²⁷ This nuanced story of medical thinking, counterposed to statistical thinking, showcases Alborn's typology of "lives" to full effect, so much that it is hard to imagine how we have been able to talk about life insurance at all without it up until now.

And how do we talk about life insurance, or insurance more generally? Metonym is central to the language of insurance, beginning with its key term, *risk*. While risk's literal meaning is the possibility of loss, it is just as often used figuratively to signify the insured: not the actual risk itself, but the individual associated with risk.²⁸ Nowhere is this semantic slippage more arresting than in life insurance. *Lives* in this specialized context is a reduction of "life" in the sense we ordinarily intend it, a boiling down of the "noble self" of personhood into the "six sheets of paper" that interest the insurer.²⁹ Whatever the ordinary meaning of this most expansive word, anyone not habituated to the language of insurance would likely find the industry's references to "lives" jarring. Imagine what an individual might consider to be "prerequisites for 'a model life'" and compare it to this 1861 medical advisor's list: "absence of scars or hoarseness, a capacious and symmetrical chest, and 'equable' pulse, and 'a considerable warmth to the skin.'"³⁰ As one Victorian novelist voiced through a character, nothing could be "more likely to destroy natural feeling . . . than to sit down with strangers and reduce his life to the measure of an insurance table,"³¹

Alborn adopts the industry-wide usage of "lives," and while he does not address this aspect of insurance rhetoric outright, he seems to put

²⁵ *Id.* at 227.

²⁶ *Id.* at 312.

²⁷ *Id.* at 270.

²⁸ BAKER, *supra* note 11, at 2.

²⁹ For a colorful quotation comparing life insurance underwriting to boiling down beef into broth, see Alborn, *supra* note 1, at 220.

³⁰ *Id.* at 269.

³¹ *Id.* at 147 (citing Edward G. Bulwer-Lytton, *My Novel*, 72 BLACKWOOD'S MAG. 53-54 (1852)).

the tension between it and a more ordinary meaning of “life” in play, and playfully so, on the book’s cover. “Regulated Lives,” on its own might suggest to a bookstore browser an account of the ways that the *activities* of living are governed. But quite the opposite of activity is the focus of life insurance, which might at least as accurately have been termed “death insurance.”³² Not only does the title put a twist on “life” as we know it, it sets up an ambiguity in and on the book’s terms. We may read these plural lives as those belonging to the Victorians themselves,³³ or as the four conceptual categories (the four “lives”) that organize this history and that, in a sense, regulate one another.

Thus the word “life” has many lives in this book, depending on which strand of modernity we are tracing. Sympathetic lives are lives entrusted to insurers. Numbered lives are counted lives and measured lives, with longer lives subsidizing shorter lives, or else ominously logged in a Registry of Declined Lives. Medicalized lives are screened lives, healthy lives, hazardous lives, or lives “looking sickly and indifferent.” And commodified lives are marginal, good, select, under-average, first class or doubtful, and lives that sometimes lapse (which of course does not entail death; rather, they just fade away and fail to pay premiums). It seems the one thing that lives are not, or at least not with any salience, is *lived*.

Through its typology of life-senses, *Regulated Lives* casts insurance as a technology that slices up the meaning of “life” and recombines the conceptual strands into new forms – a semiotic, nineteenth-century tranching and bundling of sorts. There is something psychologically odd about life insurance, though, that complexity alone does not capture. In order to insure our lives we must contemplate death . . . for the purpose of not having to think about the ramifications of death. In contemplating, we overcome denial of death’s inevitability and unpredictability, yet we insure precisely in order to *deny* death its full force, to bring some of death’s aftermath into check. In the final pages of *Regulated Lives*, Alborn captures the paradox of life insurance in the darkly incisive musings of Gregory, the insurance clerk in Julian Barnes’s novel, *Staring at the Sun*: “[W]hen it came down to it, what people were trying to do was get the best deal they could out of being dead . . . Even those who admitted that they themselves would not actually get the money could still be entranced by the transaction.”³⁴ Gregory concludes of insureds that

³² ALBORN, *supra* note 1, at 163.

³³ *See id.* at 7 (“Yet the regulated lives who bought insurance policies . . .”).

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“when departing, they struck the best deal they could. How strange. How admirable, he supposed, but how strange.”³⁵ This strangeness is what many of us find fascinating about life insurance, and about this book. Perhaps it derives from the fact that, no matter which strand of its meaning we are tracing, we are always looking at the death side of life.

³⁵ *Id.*

BOOK REVIEW: THE LANGUAGE OF *LIVES*

Jill C. Anderson

For outsiders, perhaps it is the historian's relationship to the particular that epitomizes the discipline and frames our expectations as readers. To mine boundless archival sources for shards of a story, and to fashion those odd individual shapes into a coherent one among many possible narratives -- this speaks to an intellectual calm beyond the reach of most of us. Delivering on this expectation, Timothy Alborn's *Regulated Lives: Life Insurance and British Society, 1800-1912* tells a story of a little-understood institution's path into modernity, assembled of well-chosen detail on a foundation of comprehensive research.¹ Importantly, Alborn's excavation of Victorian life insurance fills gaps in business history. But its most surprising feature, one that readers glimpse just a few pages into the book, is the sweep of its conceptual departure point: the meaning of life. And not just one meaning, but four distinct conceptualizations of modern life -- as he terms them: the sympathetic, the numbered, the medicalized, and the commodified life² -- that Alborn argues evolved during the Victorian era and are uniquely merged in the institution of life insurance.³

A preliminary project of Alborn's book is to name and strain out these life-dimensions, in something like the way a prism takes in white light and separates it into a spectrum.⁴ He then shows how those bands came to be braided together, each one developing alongside and in tension with the others as they shaped Victorian life insurance and in turn were

· Visiting Professor of Law, University of Connecticut School of Law. I am grateful to the University of Connecticut's Insurance Law Center and Pat McCoy in particular for the opportunity to share perspectives on *Regulated Lives* with Sharon Murphy, Geoff Clark, and Tom Baker, with Peter Kochenburger moderating the discussion with his usual expertise and generosity. I owe much to Susan Schmeiser for teaching me how to read more smartly and sensitively. Finally, many thanks are due Tim Alborn for giving us this important, lovingly crafted book to convene around and celebrate.

¹ TIMOTHY ALBORN, *REGULATED LIVES: LIFE INSURANCE AND BRITISH SOCIETY, 1800-1914* (2008).

² *Id.* at 7.

³ *Id.* at 7-13.

⁴ This metaphor is borrowed from the author, who uses it to depict the fragmentary nature of modernity and its resistance to being folded into grand narrative without stranding or jettisoning facts that do not follow its plot. *Id.* at 296-97.

shaped by that institution as a producer of culture. As this express project of the book unfolds, a parallel, subtler plot of sorts develops at a linguistic level. In breaking out a typology of “lives,” the author calls into service a figure of speech that is ubiquitous in life insurance and in insurance in general: *metonymy*, the non-literal use of a word to represent an associated concept.⁵ “Lives,” in the parlance of insurance, is nearly always shorthand for something associated with lives: e.g., policy holders, policies, bodies, medical subjects, breadwinners, health states, predictions of longevity, and, of course, deaths. In *Regulated Lives*, Alborn’s multiple meanings of “life” both complicate and organize the underlying, undifferentiated metonym in ways that mirror certain strange and intriguing paradoxes inherent in life insurance.

Among the fourfold typology of “lives,” we encounter first the *sympathetic life*. Within this meaning, it is one’s contemplation of dying and leaving others destitute that is essential to the demand for life insurance,⁶ and insurers aimed to generate a “sympathetic exchange” with the public.⁷ The more impersonal *numbered life* was the province of the actuary, who tabulated life expectancies and organized them into mortality tables. This was the relatively easy task, at least as it reflected mortality for “healthy males,” but actuarial science was considerably more challenged to convert mortality statistics into meaningful risk categories. While actuaries were zooming out from persons to numbers to norms (sometimes very far out, as when seeking in vain an ancient “law of mortality” in the early nineteenth century),⁸ medical examiners were focusing closely on individual bodies. In a break from therapeutic or investigative applications of medicine, they applied the latest science to scrutinize *medicalized lives* for signs of defect that would render them uninsurable.⁹ And finally, the development of these conceptual categories all took place within a

⁵ See MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY 782 (11th ed. 2003). Examples of metonymy include “the crown” to represent a monarchy or “Hollywood” as a stand-in for the American entertainment industry. See *id.*

⁶ I mean here to refer to the demand for life insurance as an income substitute for the breadwinner-insured, as opposed to the class of debtor-insureds for whom life insurance was a condition of credit. See ALBORN, *supra* note 1, at 136-37.

⁷ *Id.* at 156 (citing ELAINE HADLEY, MELODRAMATIC TACTICS: THEATRICALIZED DISSENT IN THE ENGLISH MARKETPLACE, 1800-1885 30-31 (1995)).

⁸ ALBORN, *supra* note 1, at 124.

⁹ *Id.* at 205-51.

rationalizing market that equated mortality with money, giving us the *commodified life*.¹⁰

Anyone who doubts that these categories work beyond characterizing British life insurance should consider the recent public controversy over guidelines for breast cancer screening through mammography.¹¹ When a federally appointed medical advisory panel recommended delaying routine mammograms, citing a low likelihood that more aggressive screening would save lives in significant number,¹² the ensuing public debate echoed the tensions that Alborn has identified, in another life-and-death context. Both might be characterized as sympathy meets medicine meets math meets money.¹³

These four conceptualizations of life might appear to be interrelated as natural allies or rivals with their tensions following predictable plotlines. Sympathy, for example, stands apart as humanizing life insurance, defining certain essential relations that must hold between the insurer and the insured (can the policyholder trust the insurer to be a surrogate breadwinner?) and between that insured and his dependants (is the policyholder sensitive enough to their plight to pay premiums for their benefit alone?). Symbolized in literature by the Victorian deathbed,¹⁴ the perspective of sympathy recognizes the policyholder as an individual with complex relationships and responsibilities, in contrast to the other three more objectifying dimensions.¹⁵ And just as the deathbed motif has given way in to its contemporary equivalent, the hospital bed, we might anticipate a story of life insurance's "softer feelings" losing ground to the cold rationality of the mortality table or the scrutiny of the medical examination table.

A more complex dynamic emerges in *Regulated Lives*, however, notably in the chapter on the gatekeeping practices, by which insurers excluded or charged higher premiums based on risk. Insurers in the early to mid-nineteenth century screened applicants based on interviews, referrals, and a proposal form.¹⁶ Early gatekeeping was largely

¹⁰ *Id.* at 181.

¹¹ TOM BAKER, *INSURANCE LAW AND POLICY* 158-59 (2d. ed. 2008).

¹² *Id.*

¹³ For commentary on the controversy over mammograms see, e.g., Kevin Sack, *Screening Debate Reveals Culture Clash in Medicine*, N.Y. Times, Nov. 20, 2009, at A1.

¹⁴ ALBORN, *supra* note 1, at 149.

¹⁵ See ALBORN, *supra* note 1, at 156.

¹⁶ *Id.* at 232.

interpersonal, intuitive, and trust-based; in other words, “intimate but unreliable.”¹⁷ With a widening market, a burgeoning field of diagnostic medicine, and growing mistrust of the truthfulness of applicants, insurers by 1900 had come to rely chiefly on medical examinations to police adverse selection.¹⁸ A triumph for the medicalized conception of life? Not so fast. The indignity of the medical exam made it unpopular with consumers and sales agents alike.¹⁹ Products that dispensed with the exam gained favor in the early 1900s, striking a blow for sympathy as mediated through the market.

Another surprising relationship emerges in the tension between numbered and medicalized conceptions of life, two dimensions of science that appear from a distance to reinforce each other. Starting from the baseline of confident mortality tables, it seemed to insurers that diagnostic medicine could be brought into the service of actuarial science. Medicine held the prospect of refining the sweepingly general mortality statistics by introducing meaningful risk categories. Once having identified the markers of mortality, the medical gaze could be trained on the individual body in order to screen out or rate up “inferior lives,” or so insurers hoped.

But bodies do not give up “Fate’s secrets”²⁰ easily, we learn, either individually or in the aggregate. This was true in two senses. First, being “poked and prodded” made people uneasy enough when undertaken by an attending physician for the purpose of treatment; swapping the attendant with the “medical police”²¹ and replacing therapy with evaluation only made the scrutiny more objectionable. Second, many features that were deemed abnormal (e.g., a lanky build,²² albumin in the urine,²³ etc.) turned out to be of little use as predictors of mortality. It made sense that insurers screened for lung problems in a period of rampant tuberculosis, but even some of this attention was misplaced, as when insurers took chest circumference and breathing capacity as a measure of respiratory health.²⁴ Much of Victorian gatekeeping of the medicalized life calls to mind the saw of “looking for one’s lost keys under the lamppost”: insurers tended to collect information on deviance that was easy to detect (e.g., epilepsy,

¹⁷ *Id.* at 241.

¹⁸ *Id.* at 245.

¹⁹ *Id.*

²⁰ *Id.* at 265.

²¹ *Id.* at 253.

²² *Id.* at 263.

²³ *Id.* at 267.

²⁴ *Id.* at 263.

insanity, physiognomic judgments), with disappointing results for risk classification.²⁵ But in the end – and here is the twist wrought by the numbered conception of life – there was always the law of large numbers. Medicine might take pains to sniff out pathology in applicants, but as numbered lives, those applicants were often normal enough to be insurable.²⁶ Doctors had arrived at the actuaries' starting point: "the future could be predicted only for aggregate populations and never for individuals."²⁷ This nuanced story of medical thinking, counterposed to statistical thinking, showcases Alborn's typology of "lives" to full effect, so much that it is hard to imagine how we have been able to talk about life insurance at all without it up until now.

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“when departing, they struck the best deal they could. How strange. How admirable, he supposed, but how strange.”³⁵ This strangeness is what many of us find fascinating about life insurance, and about this book. Perhaps it derives from the fact that, no matter which strand of its meaning we are tracing, we are always looking at the death side of life.

³⁵ *Id.*

REVIEW OF TIMOTHY ALBORN'S *REGULATED LIVES*

Sharon Murphy*

One of the most important recurring themes in Timothy Alborn's *Regulated Lives: Life Insurance and British Society, 1800-1914* is the idea of Victorian gatekeeping, meaning the use of application forms, statistical tables, and medical exams to carefully select only those lives that conformed to a company or industry-defined standard norm.¹ As Alborn demonstrates, this process of determining who would be permitted to join a company's pool of policyholders and at what rate of premium was fraught with anxiety not only for the applicant, but likewise for the medical doctors, sales agents, and company directors, each of whom had a stake in the success or failure of the gatekeeping process.² Yet while individual decisions regarding individual lives by individual actors were the public face of gatekeeping, the process was ultimately based on the definition of a standard normal life in the aggregate. In order both to reduce underwriting individual lives with an unacceptably higher than average probability of mortality and to set accurate premium rates, companies first had to determine average mortality rates for their target clientele.³ Ironically, for an industry dependent on actuarial tables during an era when statistical knowledge reigned supreme, numbers proved to be the Achilles' heel for life insurers. Victorian gatekeeping publicly promised a rational, scientifically-based classification of lives, yet privately delivered little more than educated guesswork with the hope that future mortality would not prove their estimations to be woefully inadequate.⁴

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¹ See, e.g., TIMOTHY ALBORN, *REGULATED LIVES: LIFE INSURANCE AND BRITISH SOCIETY 1800-1914* 220 (2009).

² *Id.* at 238-39.

³ *Id.* at 103.

⁴ *Id.* at 128, 130.

The nature of all insurance enterprises is spreading risk across a large group of people. Thus, the key to operating a successful, profitable insurance company is to accurately assess the overall risk of the entire pool of policyholders, and then to set premium rates which reflect that level of risk. But, as Alborn demonstrates, this was a particularly vexing problem for British life insurers. Not only was the process of determining average mortality much more complex than it might initially appear, but that process was further confounded by the difficulty of deciding whose mortality was relevant for compiling those tables: which people actually belonged to this group of people interested in spreading risks among themselves.⁵ If companies could assume that everyone would purchase a life insurance policy, then this problem of determining a predicted mortality experience would be greatly simplified, since it would be based on the mortality of the population as a whole. Yet in reality, not everyone desired insurance (at least not at first), and companies initially sought to underwrite only the least risky lives.⁶ Insurers thus needed to calculate tables based on the expected mortality experience of their target clientele. And whereas predicting mortality rates for the overall population was a difficult task, gauging the future mortality of a significant subset was especially daunting, not least because the attributes of this group were endlessly shifting.

On the micro level, membership within the target risk pool was subject to continuous change.⁷ Insurers had to face the problem of trying to guarantee that new individuals who joined the group did not unfavorably impact the aggregate risk profile of the body of policyholders.⁸ If a company was excessively selective in accepting policyholders, it would be in danger of having insufficient lives across whom to spread the risk adequately. Additionally, an overly restrictive target group would limit the firm's ability to increase its market share in the future. Yet by defining the parameters of the target group more broadly, companies would require even more precise knowledge of each additional applicant to ensure that the

⁵ *Id.* at 113.

⁶ *Id.* at 4.

⁷ *See, e.g.,* ALBORN, *supra* note 1, at 33-42.

⁸ *Id.* at 220-21, 271-73.

clientele was not being drawn primarily from the least favorable portion of the potential risk pool.⁹ Likewise, as companies and the industry inevitably tried to expand the life insurance market, by necessity they would need to start accepting less desirable lives. Thus, the industry needed a way to select the best lives (i.e., those predicted to live the longest among their peers), and then decide how to treat other applicants who failed to meet this highest of standards.¹⁰ This is where Alborn's gatekeeping – the personal assessment of individual risks – became so crucial.

Unfortunately, shifting parameters for the target risk pool was not the only hurdle in the development of accurate mortality tables.¹¹ Companies were trying to make predictions about mortality twenty, thirty, even forty years into the future, yet external factors impacting expected mortality on the macro level were likewise in rapid flux during the nineteenth century. For example, urbanization facilitated the spread of disease, industrialization enlarged the number of hazardous occupations, and transportation innovations encouraged travel to less salubrious climates; all of these factors increased mortality rates among certain populations. On the other hand, improvements in medical knowledge and medical care, better sanitation, access to fresh foods, etc., were lowering mortality rates for another subset of the population. Yet these factors did not merely cancel each other out; rather, they impacted different segments of the population to differing degrees, making calculations of future mortality a constantly moving target.

Therefore, the very first problem which life insurers needed to work out was the computation of accurate mortality tables, and what is most important to note here is the amount of sheer guesswork involved in this endeavor throughout the nineteenth century.¹² Yet, at the same time, the entire industry was founded upon the premise that mortality was governed by scientific laws which were easily accessed and understood by the trained company actuary.¹³ Firms

⁹ *Id.* at 220-21.

¹⁰ *Id.* at 220.

¹¹ *See, e.g., id.* at 104-05.

¹² *Id.* at 103.

¹³ ALBORN, *supra* note 1 at 134.

assured the public that they could accurately predict how many people of a given age would die in a given year, so by purchasing insurance, the policyholder was merely spreading the risk of his or her individual death across the aggregate of people of the same age.¹⁴ Life insurance advertisements and sales agents were thus adamant that life insurance was not a matter of gambling, and they pointed to countless tables of data to buttress this assertion.¹⁵

Despite their public assertions to the contrary, insurance executives throughout the nineteenth century were never certain that they had the right statistical foundation for their premium rates.¹⁶ They suspected that the available tables based on whole population data greatly overstated mortality.¹⁷ Not only did these tables include many low-income individuals for whom mortality was higher than average, but they also did not take into account the rigorous selection process of insurers.¹⁸ Yet tables based purely on a company's past experience (so-called select life tables) were likewise plagued with problems. In an industry making predictions over the long term, most companies were too young to draw accurate conclusions from their limited experience. Although industry executives understood that the benefits of careful medical selection were short-lived, most of the policies available for use in a select life table were recently acquired and thus still benefitting from that selection advantage. Finally, the crafting of a select life table based on past experience assumed that all future applicants would be similarly selected, and that it would not be necessary for the firm to loosen its selection criteria in attempting to increase its market share. One potential solution to this problem would be to adopt an overly-conservative table, returning the excess as bonuses to policyholders in mutual companies or as dividends to stockholders. Yet this option would open the door to cut-rate competition from companies employing more liberal tables. Additionally, many companies sold both life insurance and life annuities; an overly-conservative mortality

¹⁴ *Id.* at 128.

¹⁵ *Id.* at 127, 306.

¹⁶ *Id.* at 102-103.

¹⁷ *Id.* at 115.

¹⁸ *Id.* at 104.

schedule would wreak havoc on the annuity business even as it guaranteed the safety of the insurance line.

By the second half of the nineteenth century, life insurers (working mainly through the professional organization for British actuaries) would agree upon a table that they believed would serve as an acceptable basis for the selection process.¹⁹ Based on the combined experiences of twenty major life insurance offices, this “Healthy Males” table suffered from many of the same shortcomings as other select life tables.²⁰ Yet because it was so widely adopted within the industry, it set the standard for the expected mortality of healthy males at a given age²¹ (lessening the problem of cut-rate competition)²². All insurance applicants would now be judged based on their predicted adherence to this norm.²³ As data continued to accumulate, applicants once denied coverage for falling outside the acceptable risk pool were now embraced. And as mortality risks shifted, these tables would be repeatedly revised over the remainder of the century.²⁴ While the Healthy Males table was still imperfect, by working together as an industry insurers were finally able to achieve a reasonably accurate mortality table on which to base their decisions.²⁵

Of course, in setting the standard normal life of a healthy male, firms still needed to decide who fit that standard and how to deal with applicants falling outside of this category such as women, less than perfectly healthy males, or people exposed to greater mortality risks due to a dangerous occupation, residence in an unhealthy climate, or hazardous travel. Thus, even the compilation of a moderately-accurate mortality table did not eliminate the necessity of Victorian gatekeeping.²⁶ Gender, occupation, or travel were all factors which companies could identify with relative ease, choosing either to reject the applicant outright or add a surcharge to the risk

¹⁹ ALBORN, *supra* note 1, at 113.

²⁰ *Id.* at 113-14.

²¹ *Id.* at 115.

²² *Id.* at 103.

²³ *Id.* at 276-77.

²⁴ *Id.* at 284-86.

²⁵ ALBORN, *supra* note 1, at 114.

²⁶ *Id.* at 220-21.

(which, as Alborn points out, was often based more on the maximum that the market could bear rather than an accurate reflection of the nature of the risk).²⁷ Health issues, on the other hand, were of the highest concern for the industry, and the greatest efforts at Victorian gatekeeping were devoted to uncovering hidden health problems.²⁸ British life insurers were obsessed with the possibility that applicants would engage in adverse selection.²⁹ They feared that people with reason to believe their lives would fall short of the predicted longevity would be most likely to apply, and that the applicant would hide this information (either inadvertently or intentionally) from the company.³⁰

Just as companies struggled throughout the century to determine an accurate basis for their aggregate mortality tables, they likewise grappled with the problem of ascertaining the health risk posed by individual applicants.³¹ During the first half of the century, the main means of gatekeeping entailed health questions on an application form, the corroboration of these answers by reliable friends and medical attendants, and a personal appearance before the board of directors.³² However, each of these means contained serious drawbacks. As companies extended their reach beyond the metropole, it became increasingly difficult for the board to personally examine each applicant or to judge the reliability of witnesses.³³ Additionally, doctors began demanding payment for their services³⁴, yet their observations were likely to be biased in favor of their patients.³⁵

Finally, the application form depended first and foremost on the honesty of the applicant (“has the applicant *ever* spit blood?”).³⁶ Yet even when the policyholder had been completely forthcoming,

²⁷ *Id.* at 116.

²⁸ *Id.* at 221-22.

²⁹ *Id.* at 221.

³⁰ *Id.* at 220-23.

³¹ *See* ALBORN, *supra* note 1, at 220.

³² *Id.*, at 224-32.

³³ *Id.* at 232, 237.

³⁴ *Id.* at 222.

³⁵ *Id.* at 232.

³⁶ *Id.* at 224-25.

he or she may have had an underlying medical issue that was as of yet undetected, or a seemingly innocuous symptom that the applicant failed to associate with a larger medical problem.³⁷ The desire to ensure that all policyholders conformed to the “healthy male” standard set in the tables drove companies to construct ever more complicated questionnaires, demanding that applicants respond to multiple queries about numerous specific ailments or symptoms, as well as providing a detailed family history.³⁸

The gatekeeping of the application form was then reinforced with a more robust medical examination.³⁹ Rather than relying on the information provided by personal doctors, companies began hiring physicians to conduct detailed screenings of all applicants.⁴⁰ In order to facilitate comparisons across applicants and medical personnel, these exams became increasingly routinized.⁴¹ Once again, companies sought to statistically define what constituted normal characteristics for their standard healthy male.⁴² By setting parameters for acceptable height, weight, pulse, blood pressure, etc., life insurers exuded confidence that they understood the statistical impact of these factors on their standard normal life – and then could adjust rates accordingly for those who fell outside these parameters.⁴³ Yet as had been the case with the creation of mortality tables, these guidelines were of necessity a combination of sound medical knowledge and educated guesswork.⁴⁴ In attempting to numerically define and categorize applicants, firms repeatedly found their efforts thwarted by the uniqueness of individual lives.

In placing so much confidence in the accuracy and objectivity of statistics, life insurers were part of a much larger nineteenth-century phenomenon. As Geoffrey Clark already mentioned, historians such as Patricia Cline Cohen (*A Calculating People: The Spread of Numeracy in Early America*. University of Chicago Press,

³⁷ ALBORN, *supra* note 1, at 221.

³⁸ *Id.* at 225-26.

³⁹ *Id.* at 236.

⁴⁰ *Id.*

⁴¹ *Id.* at 244.

⁴² *Id.* at 261-62.

⁴³ See ALBORN, *supra* note 1, at 261-62.

⁴⁴ *Id.* at 270.

1982), Theodore M. Porter (*The Rise of Statistical Thinking, 1820-1900*. Princeton University Press, 1986), and Lorraine Daston (in *The Probabilistic Revolution*. Massachusetts Institute of Technology Press, 1990) have all documented a rapid increase in the use and acceptance of statistics in daily life during the early decades of the nineteenth century. On both sides of the Atlantic, people were becoming more numerically literate and they increasingly associated data with objective truths, subjecting to quantification not just economic questions but civic, social, and moral issues as well. For the life insurance industry, a statistical understanding of the factors contributing to mortality would not only ensure the long-term viability of the industry but would create confidence among the general public that life insurance premiums were based on scientifically sound principles and not merely a matter of chance. Yet their search for statistical surety was, of necessity, elusive. *Regulated Lives* reflects not only the nineteenth-century obsession with numbers and calculation but, more importantly, underscores the messiness and contingency inherent in that compilation of “objective truth.”

REGULATED LIVES IN HISTORIOGRAPHICAL CONTEXT

*Geoffrey Clark**

Readers of this journal are likely to be more familiar with the legal doctrines pertaining to contemporary insurance practice than they are with the scholarly roots of Timothy Alborn's *Regulated Lives: Life Insurance and British Society, 1800-1914*.¹ This essay is meant to provide some historiographical context in order that readers may appreciate the full measure of Alborn's achievements in this book.

Regulated Lives is the latest arrival on a tide of historical and sociological research into insurance appearing in the last 25 years or so. Although numerous smaller tributaries may be identified, two major streams of scholarship have led to these studies into the social and cultural history insurance. The first of these is the company history, a work typically commissioned by a firm's directors to celebrate the passing of a noteworthy milestone. All too often, especially among the older sort, these histories are cast in a heroic Victorian mold, featuring as *dramatis personae* the "Great Men" who stood at the company's helm, steadfastly navigating stormy and shark-filled waters to make their sesqui- or bicentennial ports. Gratifying tales of profit and endurance for the stockholders and employees who must have comprised the main readership of these volumes, but their aims usually did not reach beyond chronicling the progress of the firm and celebrating its success.

This is not to denigrate some really first-rate company histories written by outstanding historians that have documented the rise of the British insurance business over the past 300 years, works like P. G. M. Dickson's *The Sun Insurance Office* (1960)², Barry Supple's *Royal Exchange Assurance* (1970)³, and Clive Trebilcock's *Phoenix Assurance* (1985)⁴. But even the best of them, as Alborn himself phrases it, mainly

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¹ TIMOTHY ALBORN, *REGULATED LIVES: LIFE INSURANCE AND BRITISH SOCIETY, 1800-1914* (2009).

² P. G. M. DICKSON, *THE SUN INSURANCE OFFICE, 1710-1960: THE HISTORY OF TWO AND A HALF CENTURIES OF BRITISH INSURANCE* (1960).

³ BARRY SUPPLE, *THE ROYAL EXCHANGE ASSURANCE: A HISTORY OF BRITISH INSURANCE 1720-1970* (1970).

⁴ CLIVE TREBILCOCK, *1 PHOENIX ASSURANCE AND THE DEVELOPMENT OF BRITISH INSURANCE* (1985).

adopt the perspective of the board room.⁵ The problem is not just that the histories of remarkably successful firms must inevitably have a whiggish whiff. It is also, and more importantly, that while the companies portrayed in these accounts may suffer boardroom clashes, recalcitrant sales staffs, or the usual interdepartmental rivalries, the fundamental unit of analysis remains the firm as a monolithic entity. This perspective was adopted even by older general histories like Harold Raynes' *History of British Insurance* (1964)⁶, which narrate a story largely bounded by the field lines of company entrepreneurship, technical innovation, and state regulation.

One of the achievements of Alborn's book is to show at a much finer level of detail that the nineteenth-century British insurance business was internally driven by different constituencies working to some extent at cross-purposes because they attributed to their customers different ontological or aesthetic meanings: they were sympathetic subjects to the pitch men, forensic puzzles to medical examiners, numerical data to the actuaries, and commodities to the ledger-keepers and stockholders.⁷ And not all of these terms could dovetail into a consistent and cohesive, to say nothing of coercive, address to the insured subject. As a result, Alborn presents a view of the nineteenth-century insurance firm as pluralistic in its organization and at times internally divided in its goals, and therefore incapable of formulating and enforcing the micro-strategies of control imagined by Michel Foucault and the acolytes of "governmentality."⁸

The second major stream of scholarship leading to *Regulated Lives* and other recent studies of insurance flows from the history and philosophy of science literature on the emergence of probabilistic thinking, the development of statistical analysis, and the strikingly obsessive and pervasive reference to number as a legitimating authority in the modern world. Prominent among researchers in this field are the philosopher Ian Hacking and historians of science Ted Porter and Lorraine Daston, who are concerned with describing the epochal mental and intellectual transformations that were associated with reconceptualizations of chance, mathematics, and reason from the seventeenth through the twentieth centuries.⁹ Although this body of scholarship is impressive in its ambition

⁵ ALBORN, *supra* note 1, at 13-14.

⁶ HAROLD E. RAYNES, *A HISTORY OF BRITISH INSURANCE* (2nd ed. 1964).

⁷ ALBORN, *supra* note 1, at 7-13.

⁸ *Id.* at 7.

⁹ See IAN HACKING, *THE EMERGENCE OF PROBABILITY: A PHILOSOPHICAL STUDY OF EARLY IDEAS ABOUT PROBABILITY, INDUCTION AND STATISTICAL INFERENCE* (2006); THEODORE M. PORTER, *THE RISE OF STATISTICAL THINKING, 1820-1900* (photo. reprint 1988) (1986); LORRAINE DASTON & MICHAEL STOLLEIS,

and scope, and while it has greatly influenced researchers in a variety of fields, its preoccupation with seismic shifts in the history of ideas inevitably give short shrift to the nitty-gritty details of how, and to what extent, probabilism and statistical technique were absorbed into what Daston refers to as “the practice of risk” in her seminal *Classical Probability in the Enlightenment* (1988).¹⁰ But it is worth noting that it was only at the urging of the distinguished historian of science Charles Gillespie, who thought her initial draft too absorbed in theory in her book, that Daston added a chapter on the concrete application of probability theory to risk-taking and insurance.

We have then in these two scholarly streams the truffle-hunting company historians narrowly focused on the fortunes of the firm, and the parachutist intellectual historians attentive to shifting conceptual landscapes but less adept at tracing the details of how probability and statistics were translated into practical activity. The recent wave of insurance histories has sought to bridge this gap between the aerialists and the troglodytes by joining business and economic history with social and cultural history. *Regulated Lives* stakes out this new ground for the period in which Britain’s life insurance industry grew to maturity. It stands alongside Robin Pearson’s *Insuring the Industrial Revolution: Fire Insurance in Great Britain, 1700-1850* (2004)¹¹ and my own *Betting on Lives: The Culture of Life Insurance in England, 1695-1775* (1999)¹² in providing synthetic studies of the development of the British insurance market (in most respects the progenitor of the modern insurance business) while also teasing out the meanings of insurance to various market participants and in the culture at large.¹³

In comparing my account of the early formation of the British insurance market in the seventeenth and eighteenth centuries with Alborn’s account of its subsequent development across the long nineteenth century, the continuities in business practice and culture are more striking than the dissimilarities. This is a surprising result given the widely shared assumption by experts that the character of life insurance fundamentally

NATURAL LAW AND LAWS OF NATURE IN EARLY MODERN EUROPE: JURISPRUDENCE, THEOLOGY, MORAL AND NATURAL PHILOSOPHY (2008).

¹⁰ LORRAINE DASTON, *CLASSICAL PROBABILITY IN THE ENLIGHTENMENT* 112 (photo. reprint 1995) (1988).

¹¹ ROBIN PEARSON, *INSURING THE INDUSTRIAL REVOLUTION: FIRE INSURANCE IN GREAT BRITAIN, 1700-1850* (2004).

¹² GEOFFREY CLARK, *BETTING ON LIVES: THE CULTURE OF LIFE INSURANCE IN ENGLAND, 1695-1775* (1999).

¹³ See ALBORN, *supra* note 1, at 7-13.

changed after the foundation, in 1762, of the Equitable Society (the first firm to issue sell “modern” age-based premium insurance) and the appearance of several imitators near the end of the eighteenth century.¹⁴ Alborn shows that, despite refinements in actuarial knowledge, product design, marketing, and medical screening, in important respects the life insurance industry displayed the same tentative reliance on actuarial data and appealed to the same speculative tastes of its customers as it did in the previous century.¹⁵

Nineteenth-century actuaries, for example, generated a succession of mortality tables that generally confirmed one another’s evaluations of the risk of death at specified ages – the risk of mortality, that is, among middle-class adult males, a group that actuaries established as a standard reference population.¹⁶ It had been obvious to Daniel Defoe as far back as the 1690s that other factors such as occupation or place of residence were likely to be at least as important as age in determining the likelihood of death.¹⁷ 150 years later actuaries showed little inclination to compile mortality tables that quantified those risks or to calculate the mortality profile for “non-standard” populations like women or the working classes.¹⁸ Instead, insurers resorted to other techniques for coping with increased quanta of risk (or at least the increased uncertainty of risk) posed by these groups. One such method was termed “rating up” of under average lives, an intuitive procedure by which insurers notionally added some number of years to proposed lives that would compensate for their perceived deficiencies in health and habits from those of good male lives of the same age.¹⁹ In other words, insurers took their carefully calibrated demographic scales and then crudely pressed their thumbs down on one side in order to make them appear in balance.

Another method of reckoning with demographic uncertainty involved the office of the marketer rather than the actuary. Rather than investing the time and effort to attain systematic mortality data of select populations with differing demographic profiles, insurers cannily shunted higher-risk lives into endowment insurance or contingent debt policies, which provided a financial inducement to purchasers to live long.²⁰ These

¹⁴ CLARK, *supra* note 13, at 72; *see also* FREDERICK BLAYNEY, A PRACTICAL TREATISE ON LIFE ASSURANCE 5-6 (2nd ed. 1837).

¹⁵ *See* ALBORN, *supra* note 1, at 16.

¹⁶ *Id.* at 9.

¹⁷ DANIEL DEFOE, AN ESSAY UPON PROJECTS 70 (BiblioBazaar 2008) (1697).

¹⁸ *See* ALBORN, *supra* note 1, at 116-18.

¹⁹ *Id.* at 116-17.

²⁰ *Id.* at 195-96.

highly successful marketing devices transferred some demographic risk from the firm to the consumer, who effectively bet on his or her own longevity, a speculative atavism from eighteenth-century life insurance.²¹

This speculative dimension of life insurance was also carried into the nineteenth century through the bonus system, another device popular with the public in which companies periodically distributed accumulated excess premiums among policyholders.²² The insurance bonus generated demand by giving life insurance the appearance of paying dividends in the medium term like other investments.²³ It also reflected firms' enduring caution in relying too heavily on actuarial data, and their corresponding conservatism in maintaining premiums above their true value, again, an approach characteristic of eighteenth-century life insurance companies.²⁴

A third noteworthy thread of continuity pertains to the medical screening of lives proposed for insurance. The fact that insurers in the Victorian era ultimately limited their use of medical surveillance, acquiescing in the face of market competition to regard as acceptable lives deemed "normal enough," recall the loose and intuitive (although admittedly less discriminating) classification of insurable lives in the eighteenth century as those drawn from a broadly defined prime of life and not obviously infirm or besotted.²⁵

One of those lives rejected by insurance offices belonged to Robert Louis Stevenson, whose "crazy health," as he himself described it, made him absolutely uninsurable.²⁶ (The offices proved right: he died aged 44.)²⁷ But Stevenson did live long enough to exact some literary revenge in a novella he wrote with Lloyd Osbourne titled *The Wrong Box*, a comedy of errors about the maniacal winding up of a tontine.²⁸ One of the book's central characters is an insufferable pedant and middle-class improver named Joseph Finsbury, the author of several edifying essays including "'Life Insurance Regarded in its Relation to the Masses'," read before the Working Men's Mutual Improvement Society, Isle of Dogs, . . . [and] received with a 'literal ovation' by an unintelligent audience of both

²¹ *Id.* at 198-99.

²² *Id.* at 166-69.

²³ *Id.* at 177-80.

²⁴ See ALBORN, *supra* note 1, at 178-79.

²⁵ *Id.* at 249.

²⁶ *Id.* at 11.

²⁷ A Robert Louis Stevenson Timeline, <http://www.robert-louis-stevenson.org/timeline> (last visited Apr. 8, 2010).

²⁸ ROBERT L. STEVENSON AND LLOYD OSBOURNE, *THE WRONG BOX* (Charles Scribner's Sons 1889) (1889).

sexes.”²⁹ Stevenson’s caricature of the middle class’s moralistic condescension in recommending the manifold benefits of life insurance, as well as the working class’s uncomprehending assent to professional expertise and numerical authority, has a recognizable basis in Alborn’s description of the social dynamics of Victorian life insurance.³⁰ Many companies – not least the growing cadre of “industrial” offices – moved down market to enlist the multitude of laboring families in the cause of financial improvement and social respectability. Alborn also demonstrates that the mathematical basis of insurance – its legitimating scientific foundation – was roundly ignored by customers who were swayed much more by emotional appeals than by the calculus of mortality, whose authority they uncritically accepted.³¹

Finally, Stevenson’s hilarious juxtaposition of Finsbury’s vaunting praise of life insurance with its tepid reception by his audience suggests something about the limitations of insurance to subject people’s lives to its manifold controls.³² Alborn not only describes the difficulty of bending all parts of the insurance bureaucracy towards a common goal, he observes that the objects of that bureaucratic control evaded or transcended the categories into which the insurance industry tried to place them.³³ Despite the implication of its title, *Regulated Lives* is in fact an optimistic book. Optimistic, because it suggests that the widely feared totalizing capabilities of modern financial and bureaucratic institutions is exaggerated and that insurance companies, however grandiose their real or imagined ambitions, are too compromised from within and too vulnerable to rivals from without to exert too exact a control over our bodies and our lives. This is an insight well worth celebrating, along with this superb book.

²⁹ *Id.* at 4-5.

³⁰ See ALBORN, *supra* note 1, at 193.

³¹ *Id.* at 129.

³² See STEVENSON AND OSBOURNE, *supra* note 29, at 33-34.

³³ See ALBORN, *supra* note 1, at 298-300.

AUTHOR RESPONSE: *REGULATED LIVES*

Timothy Alborn*

To repeat one of the acknowledgements in my book, I wish to thank the University of Connecticut School of Law for so directly shaping the direction *Regulated Lives* took as it evolved over the past decade; and more specifically, in this case, for sponsoring such a stimulating (and flattering) discussion of my book earlier this year. (That panel discussion, which was the genesis of the three reviews to which I've been asked to respond, also featured stimulating comments from Tom Baker and Patricia McCoy, the past and present directors of the Insurance Law Center.) The privilege of responding to such incisive reviews accompanies several opportunities: to rethink imperfections in execution, to elaborate on some unfinished business, and to smuggle in a few historical "out-takes" that will assist me in carrying out the first two tasks.

To start with the book's title, *Regulated Lives*. All three reviewers imply, more or less directly, that this title is not quite right, since the insured lives discussed therein were not quite regulated. As Sharon Murphy points out, actuaries did not know as much as they often claimed regarding the statistical laws dictating morality; as Geoffrey Clark points out, medical screening techniques often had more in common with the eighteenth-century gatekeeping devices he describes in *Betting on Lives* than with obviously "modern" diagnostic methods; and as Jill Anderson points out, the title *Regulated Lives* implies a book about "the activities of living" but in fact contains a more ambiguous "typology of life-senses." Sharon Murphy made a similar point more critically in her review of my book for EH.net: "the voice of the insuring consumer is largely absent, appearing only as reflected by the firms themselves."¹

So is there a meaningful sense in which the lives discussed in this book (however they might have been defined) *were* regulated? I would argue that there is: namely, the large extent to which the various groups who were involved in the industry *thought* they were engaging in forms of regulation, and—even when they consciously fell short of their aspirations—kept trying to do so for most of the nineteenth century. The

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¹ Sharon Ann Murphy, review of TIMOTHY ALBORN, *REGULATED LIVES: LIFE INSURANCE AND BRITISH SOCIETY, 1800-1914*, EH.net (<http://eh.net/bookreviews/>).

search for a hoped-for “law of mortality” lurked in actuarial papers into the 1880s, and doctors continued to insist that their careful medical examinations were vital to the success of life insurance, in the face of mounting evidence that they made little difference. In their persistent ambition to regulate their customers’ lives, the actuaries and doctors in my book represented a very significant break with Clark’s eighteenth-century actors. In the process, they contributed to an increasingly regulatory *culture*, albeit one whose reach has often been exaggerated.

In the realm of statistics, a useful contrast can and should be drawn between eighteenth-century demographic thought, which (as Clark states in *Betting on Lives*) “did not possess the immediate and overwhelming persuasiveness that many historians have attributed to statistical knowledge” (118),² and a nineteenth-century belief in a “law of mortality” that hovered between religious faith and scientific certainty. As Murphy points out, there was a wide gap between this belief and what was statistically possible for much of the century (although not as wide as she implies, since the tables they used adequately corrected for the inclusion of lower-income individuals). Some of this actuarial hubris derived from the training of nineteenth-century insurance technicians, which tended towards astronomy and mathematical physics: Augustus De Morgan and Benjamin Gompertz (to cite two examples) extended the order they saw in the heavens to the human populations who bought life insurance. Some of it, as I point out in my book, derived from the marriage of convenience between this sincere form of certainty and the more dodgy variety expressed by salesmen, who were eager to use the scientific basis of life insurance to divert policyholders’ attention from the periodic waves of severe uncertainty that enveloped its financial side.

Medical practice in the nineteenth century, especially prior to the “therapeutic revolution” just before the century’s end, fell famously short of what anyone would define as “modern medicine.” Hence it comes as no surprise that medical surveillance in life insurance recalled what Clark calls the “loose and intuitive” methods of an earlier era. Rather more surprising is the extent to which life insurance companies insisted on medical screening at all, given the discipline’s modest diagnostic capacity and the availability of actuarial fixes (endowment policies and contingent debt schemes) that rendered medical exams largely unnecessary. An explanation for this puzzle, as Murphy implies, lies in the strange mixture of hubris and paranoia on the part of company directors. With prominent

² GEOFFREY CLARK, *BETTING ON LIVES: THE CULTURE OF LIFE INSURANCE IN ENGLAND, 1695-1775*, 118 (1999).

London physicians whispering in their ears, companies set in motion a proliferating arsenal of screening techniques between 1850 and 1920; at the same time, they never retreated from their conviction that adverse selection was a serious threat to their bottom line. Here again, I would argue, we find a perverse desire to regulate (among doctors and directors alike) in the face of evidence that these regulatory devices accomplished little beyond scaring customers away.

Insurance salesmen often appear in my story as policyholders' allies, who deflected the regulatory urge of actuaries, doctors, and managers. They not only played the role of friend to the insured, they often actually *were* friends of the insured—their wide circles of friends were why they got the job in the first place. Hence we find them going to bat for policyholders to reduce extra premiums, settle contested claims, and otherwise soften the industry's unbending façade. What I would add to this story (and in keeping with my claim about a regulatory *culture* that pervaded Victorian Britain) is the sheer volume of oppressively hot air that these insurance agents added, bellows-like, to the Victorian tropes of domestic duty and sentimental morality. Even though these salesmen mostly preached to the converted, their message—multiplied thousands of times over—added to a general Victorian culture that was ceaselessly intent on teaching people how to improve their lives.

All this adds up to a distinctly regulatory culture in which the whole (what Clark calls “the widely feared totalizing capabilities of modern financial and bureaucratic institutions”) is often a good deal less than the sum of its parts. One very good reason for this, as I emphasize in my book, was the fractured nature of expertise that comprises any regulatory regime. The lives in my book achieved relative autonomy precisely because they were subject to regulation by so many different people. If one doctor didn't give candidates for insurance the answer they was looking for, they could try another down the street. If one company required a medical exam, would-be policyholders could try their luck with another that was willing to substitute a double-or-nothing bet for a safer, if more stringent, contract. This range of choices yielded a paradox, which remains with us to this day in most avenues of modern life. Trust in expertise has increased over time, in large part because consumers are able to choose which experts to trust. For the same reason, trust in specific groups of experts has diminished: witness any opinion poll reporting trust in bankers, doctors, lawyers, and the like. These are still regulated lives—just not overweeningly so.

For those who find this defense of my book's title unconvincing, Jill Anderson has, at least, pointed to a possibly more accurate title waiting

in the wings: *Meanings of Life*. Perhaps the least obvious meaning of life that I described in *Regulated Lives*, but the one that (as Anderson shrewdly observes) is at the core of life insurance, is life's opposite—namely, death. Death, in more fancy terms, is life's "other," without which it would be hard to pin down what it means to us. Anderson suggests that "we are always looking at the death side of life." True enough, especially in reference to this book—but among the other services that the various meanings of life (commodification, medicalization, and so on) were called on to perform, one of the most important was their capacity for distancing the insured subject from having to tackle death head-on. We can start with the obvious fact that the business is called life insurance, not death insurance; and that society appears to have moved from less to more euphemistic in this regard (sickness insurance has become health insurance, and fire insurance has become homeowners insurance).

As one would expect, the commodification of life has always been a handy expedient for distracting policyholders from the fact of their ultimate demise, even as it deadens the activity of living. Translating death into the prospect of financial reward performs the same basic alienating function that is performed by translating labor into wages. Hence the policyholders in *Staring at the Sun* were "entranced by the transaction" whereby they got "the best deal out of being dead."³ Here, in bold strokes suitable to the edgy late-twentieth century tone of the novel, is the essence of commodification, which is capable making death itself seem like an entrancing opportunity. A Victorian take on the same phenomenon makes the strangeness of this process even clearer: Elizabeth Gaskell, in describing the human scenery of Yorkshire for her biography of Charlotte Brontë, recounted that "West Riding men are sleuth-hounds in pursuit of money," and demonstrated this axiom by referring to a small manufacturer who "fell ill of an acute disease" shortly after buying an insurance policy. When a doctor informed him of his "hopeless state," the man jumped for joy, exclaiming: "By jingo!... I shall *do* the insurance company! I always was a lucky fellow!"⁴

Here we have a nice illustration of what Clark calls "a speculative atavism from eighteenth-century insurance"; though why we should think of it as atavistic puzzles me, since speculation never disappeared as the lifeblood of the financial industry. But Victorians had their limits, as well.

³ See TIMOTHY ALBORN, *REGULATED LIVES: LIFE INSURANCE AND BRITISH SOCIETY 1800-1914* 311 (2009).

⁴ ELIZABETH GASKELL, *THE LIFE OF CHARLOTTE BRONTË*, 18 (Penguin Books, 1997).

In this context it's worth lingering a bit longer on Clark's example of *The Wrong Box*, which he uses to illustrate the revenge of the uninsurable (in this case the sickly Robert Louis Stevenson). Victorian critics vilified the book—not because it poked fun at the middle-class moralism associated with life insurance, but because Stevenson refused to deviate sufficiently from death. The book's sense of humor, according to one typical review, was “revolting when one stays to consider for a moment its nauseating subject—a corpse left unburied and unembalmed for several days, and hustled here and there!” The reviewer concluded that “the whole book is in unpardonably bad taste; its decency is less than the decency of savages.”⁵ The balancing act between speculative allusions to death and “savage decency” was one of the many fine lines life insurance companies needed to walk in the nineteenth century. Viewed from a wider angle, the tension between selling a sense of security and anticipating misfortune has remained central to all forms of insurance down to the present time.

⁵ *The Wrong Box*, 20 *THE LITERARY WORLD* 236, 237 (1889).

INTO THE UNKNOWN: THE REACH OF ENVIRONMENTAL INSURANCE IN CASES

Caroline Vazquez

I. INTRODUCTION

Brownfields are the next development frontier in many urban areas.¹ Even the economic recession has failed to deter developers from entering into new projects focused on reclaiming contaminated sites.² Developers continue to strike deals with municipalities that are hungry for new tax revenue, and find state authorities steadfastly ready to help, despite the country's struggling real estate market and general financial disarray.³

But, any purchase or planned redevelopment of a brownfield can have large, sometimes unforeseen, costs. A brownfield is a site with "actual or perceived contamination," but with a "realistic potential for redevelopment."⁴ Brownfield rehabilitation generally "involves the sale of a former industrial, commercial or institutional property to a developer who intends to redevelop the site for a 'less intensive use.'"⁵ Experts estimate that the total remaining costs of decontaminating these polluted sites in the United States may range from \$700 billion to \$1 trillion,⁶ excluding perhaps "tens if not hundreds of billions of dollars more" in potential toxic tort suits and industrial spills.⁷ In the face of these potentially huge

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¹ See J. Alex Tarquinio, *Once Polluted, Now Profitable for New Jersey Builders*, N.Y. TIMES, Mar. 5, 2008, available at <http://nytimes.com/2008/03/05/business/05brown.html>; see also, Antoinette Martin, *Why Dumps are Gaining Allure*, N.Y. TIMES, Mar. 30, 2008, available at <http://nytimes.com/2008/03/30/realestate/30njzo.html>.

² Antoinette Martin, *Reclaiming Contaminated Sites*, N.Y. TIMES, Nov. 1, 2009, available at <http://nytimes.com/2009/11/01/realestate/01njzo.html>.

³ See *id.*

⁴ Janice E. Falini, *Using Environmental Insurance to Manage Risk Encountered in Non-Traditional Transactions*, 14 VILL. ENVTL. L.J. 95, 108 (2003).

⁵ *Id.*

⁶ DAVID J. DYBDAHL, AM. RISK MGNT. RES. NETWORK, A USER'S GUIDE TO ENVIRONMENTAL INSURANCE 13, available at <http://erraconline.org/usersguide.pdf>.

⁷ Amanda Cohen Leiter, *Environmental Insurance: Does it Defy the Rules?*, 25 HARV. ENVTL. L. REV. 259, 259, 261 (2001) (arguing that the Shavell model of

liabilities, transactions involving brownfields become contentious when the parties negotiate rehabilitation cost estimates and the closure of future liabilities.⁸ Typically, the seller wants to minimize its indemnification obligations to the developer and achieve regulatory closure, while the buyer wants to quantify accurately and carefully manage future costs and potential liabilities.⁹

The buyer's concerns about unexpected clean-up costs and liabilities can destroy transactions and prevent the rehabilitation of land otherwise slated for redevelopment. For example, unexpected contamination halted a transaction between an auto body shop seeking to sell its land and a clothing retailer looking to build a fourth boutique.¹⁰ The retailer was enthusiastic about the deal until a site inspector developed an allergic reaction from exposure to chemicals once used for paint and enamel work.¹¹ When the contamination was discovered, the retailer angrily backed out of the agreement, claiming the seller had failed to disclose this pollution.¹² Environmental insurance might have saved this deal, protecting the buyer from cost overruns and liability associated with unknown contamination and providing the seller with protection from liabilities arising after the sale.¹³

Insurance makes transactions involving these contaminated sites more feasible and makes ownership of such properties with questionable use histories less risky.¹⁴ For example, a zoo in Fort Worth, Texas discovered that it sat on land that had served other, possibly industrial, purposes in the past.¹⁵ The zoo's general liability policy did not cover environmental liability risks, leading it to seek additional insurance to fill

insurance, which emphasizes the compensation and deterrence functions of insurance, undervalues the public compensation function in the environmental rehabilitation context and noting that a well-functioning environmental insurance market encourages socially beneficial but risky ventures).

⁸ See generally *id.*; DYBDAHL, *supra* note 6.

⁹ See generally; DYBDAHL, *supra* note 6; Leiter, *supra* note 7.

¹⁰ John Butler, *When You Buy Polluted Land*, LEGAL TIMES, Nov. 14, 2005.

¹¹ See *id.*

¹² *Id.*

¹³ See *id.*

¹⁴ See Falini, *supra* note 4, at 109; see also Julianne Kurdila & Rindfleisch, *Funding Opportunities for Brownfield Redevelopment*, 34 B.C. ENVTL. AFF. L. REV. 479, 499-500 (2007) (citations omitted).

¹⁵ Purva Patel, *Pollution Insurance Has Broad Market: Municipalities, Developers, Even Zoos Are Buying It*, HOUS. CHRON., Nov. 9, 2007.

the gap in coverage.¹⁶ The zoo negotiated and paid a one-time \$20,000 premium for a three-year environmental insurance policy with a \$3 million cap.¹⁷ The zoo's chief operating officer explained, "I can't imagine what could be under [the zoo's land], but [the policy] was just a fairly inexpensive way to make sure that gap in our liability was covered."¹⁸ The environmental insurance policy thus mediated the zoo's risk of incurring large costs down the road.

In addition to mediating risk, environmental insurance policies can help developers secure financing for their projects.¹⁹ Lenders are willing to provide funding up to the market value of a property, but may not cover the excess costs that are inherent to brownfields, such as environmental assessments, remedial plans and cleanup.²⁰ By keeping remediation costs close to initial estimates for the developer, insurance can fill some of this "financing gap" that would otherwise forestall remediation projects.²¹

Even as environmental insurance facilitates brownfield rehabilitation, the increasing popularity of these projects is contributing to the growth of the environmental insurance market.²² The growing appeal of brownfield projects can be attributed to a number of factors.²³ In particular, developers are encountering improved regulatory predictability and incentives on federal and state levels.²⁴ A federal district court in California noted how state and federal initiatives were expediting brownfield cleanups by reducing "the cost and burden of returning such properties to beneficial use."²⁵ The court observed that these laws had

¹⁶ *Id.*

¹⁷ *See id.*

¹⁸ *Id.*

¹⁹ *See* Falini, *supra* note 4, at 104; *see also*, Patel, *supra* note 15.

²⁰ Kurdila & Rindfleisch, *supra* note 14, at 480.

²¹ *See id.* at 498-500.

²² *See generally* Kurdila & Rindfleisch, *supra* note 14.

²³ *See* William H. Howard, *New Issues in Environmental Risk Insurance*, 40 TORT TRIAL & INS. PRAC. L.J. 957, 957 (2005); *see also* Tarquinio, *supra* note 1; Martin, *supra* note 1.

²⁴ *See* Tarquinio, *supra* note 1; *see generally* Kurdila & Rindfleisch, *supra* note 14 (providing an overview of funding and other incentives from state and federal government sources).

²⁵ *Fireman's Fund Ins. Co. v. City of Lodi, CA*, 302 F.3d 928, 928, 948 (9th Cir. 2002) (citations omitted) (involving an action brought by insurers against city and city officials to prevent enforcement of a municipal ordinance permitting the city to investigate and remediate hazardous waste contamination of soil and groundwater).

achieved “some level of predictability” for developers, allowing them to make reasonable estimates of the costs and liabilities associated with taking on a cleanup.²⁶ “Such certainty,” the court stated, “to the extent that it is available, greatly encourages prospective purchasers to rehabilitate contaminated property and put it back into productive use.”²⁷

Developers are also finding that brownfields are increasingly competitive investments relative to other properties on the market. In some areas, preservation efforts have removed undeveloped land from the market.²⁸ And, towns are willing to strike compelling deals with developers, permitting denser development of a brownfield than the town would otherwise permit in exchange for the developer taking the property off the municipality’s hands and overseeing its cleanup.²⁹ Indeed, developers can combine municipal, state, and federal incentives, which can make brownfield redevelopment a more profitable investment than building on an uncontaminated site.³⁰ Developers can sometimes get a substantial proportion of their investment in brownfields returned to them through government subsidies more quickly than they would see a return on their investment in an uncontaminated property.³¹ Market forces and government incentives are thus making brownfield projects appealing investments for developers willing to purchase environmental insurance to keep attendant risks within reasonable limits.³²

Insurance’s risk-spreading function compliments regulatory and market incentives in reducing the deterrent effects of pollution liabilities.³³ Estimates indicate that insurance could pay for as much as two-thirds of the decontamination costs for U.S. brownfields.³⁴ With brownfields becoming increasingly attractive investments, the global market for environmental insurance policies has grown from an estimated \$500 million in 1993 to between \$2 billion and \$3 billion in recent years, with the big sellers including American International Group (AIG), ACE, Zurich, Liberty Mutual, and Chubb.³⁵ Environmental insurance is thus becoming an

²⁶ *Id.* at 948.

²⁷ *Id.*

²⁸ *See* Tarquinio, *supra* note 1.

²⁹ *See* Martin, *supra* note 1.

³⁰ *See id.*; Tarquinio, *supra* note 1.

³¹ *See* Tarquinio, *supra* note 1.

³² *See generally* Martin, *supra* note 1; Tarquinio, *supra* note 1.

³³ *See generally* Martin, *supra* note 1; Tarquinio, *supra* note 1.

³⁴ Leiter, *supra* note 7, at 259.

³⁵ Patel, *supra* note 15, at 1-2.

indispensable and broadly accepted tool for development projects with a known or suspected risk of contamination.³⁶

This article examines the role of environmental insurance policies in the remediation of contaminated lands. Section II provides background on environmental insurance policies, describing how the policies developed to fill a gap in coverage caused by general liability insurance “absolute pollution exclusions” and detailing specific types of environmental insurance contracts in current use. Section II argues that complex negotiations, and attendant expenses, associated with environmental insurance policies have reduced parties’ incentive to litigate, such that the first disputes have only recently begun to be heard in court. Section III and IV discuss recent litigation on environmental insurance policies. Section III provides a framework based on recent litigation for interpreting environmental insurance policies and argues that courts should consider the web of agreements that may influence a policy. Section IV discusses recent litigation regarding “known conditions” exclusions. Section IV argues that *contra proferentem* should generally apply to these exclusions where the scope of “known conditions” is ambiguous to encourage insurers to assume an information-forcing role when issuing coverage.

II. THE ENVIRONMENTAL INSURANCE LANDSCAPE

A. THE DEVELOPMENT OF ENVIRONMENTAL INSURANCE POLICIES

Policies explicitly covering pollution costs and liabilities have emerged only since the late 1980s in their modern form.³⁷ They developed to fill a gap that insurers purposefully manufactured in Commercial General Liability (CGL) policies,³⁸ which provide businesses with broad coverage for liabilities not specifically excluded by the policy’s terms.³⁹

Prior to the 1970s, CGL policies did not specifically exclude pollution coverage; but then, modern environmental liability law and the concurrent demand for pollution coverage did not yet exist.⁴⁰ Growing awareness of environmental issues and risks combined with federal

³⁶ See *id.*; see also Howard, *supra* note 23, at 957-58.

³⁷ See Falini, *supra* note 4, at 95-97.

³⁸ See DYBDAHL, *supra* note 6, at 17.

³⁹ Ralph A. DeMeo, et al., *Insuring Against Environmental Unknowns*, 12 J. LAND USE & ENVTL. L. 61, 62 (2007).

⁴⁰ See *id.* at 63.

legislation such as the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) and the Resource Conservation and Recovery Act (RCRA), which forced businesses to bear the costs of remediating the environmental harms they caused, led businesses to bring claims for pollution liabilities under their CGL policies.⁴¹ Insurers had not anticipated the number and scope of these environmental claims and began taking steps to exclude pollution-related liabilities for future policyholders.⁴²

Insurers meandered somewhat before excluding pollution liabilities from CGL policies entirely. To relieve the pressure on CGL policies, insurers introduced a “sudden and accidental” occurrence exclusion in 1973, which was intended to exclude leaks and spills of contaminants from coverage.⁴³ However, courts found the exclusion ambiguous and required insurers to cover many pollution liabilities regardless.⁴⁴ Thus, in 1985, many CGL policies included “absolute pollution exclusions,”⁴⁵ broadly defining the exclusion to ensure no ambiguity.⁴⁶ Thereafter, policyholders faced with pollution liabilities could not obtain coverage under their CGL policies.

Demand for environmental coverage remained even as CGL policies solidified the “absolute pollution” exclusion.⁴⁷ In response, insurance policies that specifically covered environmental risks gradually entered the market,⁴⁸ with demand intensifying throughout the 1980s.⁴⁹ Reasons for the spike in demand included growing corporate concern over environmental risks and disclosure requirements, financial incentives for

⁴¹ See *supra* n. 14-28 and accompanying text; see also John Conley, *Hidden Dangers: Taking Uncertainty Out of Mergers and Acquisitions*, 47 RISK MGMT. 12, 14 (2000) (explaining environmental insurance developed in response to legislation that required clean-up of contaminated properties); Falini, *supra* note 4, at 95 (noting that insurers created environmental insurance policies in response to government legislation that increased environmental liabilities during the 1970s).

⁴² See *supra* n.14-19 and accompanying text.

⁴³ See Kenneth S. Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 VA. L. REV. 85, 93, 97 (2001).

⁴⁴ See *id.* at 97.

⁴⁵ See *id.* at 99.

⁴⁶ Falini, *supra* note 4, at 96 & n.14.

⁴⁷ See DYBDAHL, *supra* note 6, at 1, 19-20; see also Falini, *supra* note 4, at 95-97 (“Environmental insurance has been available for commercial clients since 1979.”).

⁴⁸ DYBDAHL, *supra* note 6, at 1.

⁴⁹ Falini, *supra* note 4, at 97 & n.16.

redevelopment of brownfields, and stricter enforcement of federal and state environmental laws.⁵⁰ Moreover, developers began finding projects on contaminated sites to be savvy business decisions, but required insurance to mitigate the financial risks associated with rehabilitation projects.⁵¹

Today, the annual sales volume for environmental insurance exceeds \$1 billion and continues to grow.⁵² By 2002, demand for environmental insurance was growing at a twenty percent annual rate to more than \$2 billion of premiums.⁵³ This growth is particularly striking in contrast to the 1990s “when premium volume was less than one-tenth the current level.”⁵⁴ This growing market contains numerous, highly specialized policies, each covering a particular type of risk associated with projects on potentially contaminated lands.

B. AN OVERVIEW OF MODERN ENVIRONMENTAL INSURANCE POLICIES

Pollution Legal Liability (PLL) policies⁵⁵ and Cost Cap policies dominate the market for environmental insurance, although the options continue to diversify.⁵⁶ PLL policies provide third-party insurance coverage against liability resulting from contamination at or emanating from properties that the policy covers.⁵⁷ More specifically, PLL policies

⁵⁰ Howard, *supra* note 23, at 957-58; *see also* Brent C. Anderson, *Valuation of Environmentally Impaired Properties*, 15 NAT. RESOURCES & ENVT. 100, 137 (2000) (“Environmental insurance has been in the marketplace for the past decade. However, only in the past several years has it become a viable means of transferring environmental risks.”).

⁵¹ *See supra* notes 23-36 and accompanying text.

⁵² DYBDAHL, *supra* note 6, at 1.

⁵³ Howard, *supra* note 23, at 957 n.1.

⁵⁴ *Id.*; *see also* Dave Lenckus, *Pollution Risk Transfer Continuing to Evolve: Market for Clean-up Coverage Growing*, 36 BUS. INS., June 10, 2002, at 10.

⁵⁵ The precise name for the policy varies somewhat by insurer. Alternate names include “Pollution Legal Liability Select,” “Environmental Impairment Liability,” and “Pollution and Remediation Legal Liability.” DeMeo et al., *supra* note 39, at 76.

⁵⁶ Newer, highly specialized forms of environmental insurance have emerged that are “considerably more tailored” than their broader predecessor environmental insurance policies. These specialized policies are often geared towards specific industries, such as education, health care, or real estate development. Howard, *supra* note 23, at 958-60; *see also* DeMeo, *supra* note 39, at 82.

⁵⁷ Howard, *supra* note 23, at 959.

offer claims-made⁵⁸ coverage for on-site cleanup of unknown preexisting and new conditions, off-site cleanup resulting from unknown preexisting or new conditions, and coverage for injuries occurring on neighboring property.⁵⁹ Such policies may also include coverage for third-party claims for bodily injury and property damage, liability arising from waste transportation, business interruption, and a duty to defend.⁶⁰

Cost Cap policies compliment PLL policies. Whereas PLL policies protect against liabilities associated with the remediation of unknown environmental harms and resulting injuries to people and property,⁶¹ Cost Cap insurance protects parties that plan to remediate a site from vastly exceeding their estimated costs.⁶² Cost Cap insurance is thus “designed to address the risk and uncertainty associated with beginning an environmental remediation project.”⁶³ Insurers design the policies to cover clean-up expenses that accrue beyond expectations and the “self-insured retention,” which functions as the policy’s deductible.⁶⁴

To obtain coverage, the policyholder must submit detailed plans and cost estimates from environmental consultants to insurers,⁶⁵ who require “substantial analytical data, agency-approved work plans, sophisticated cost estimates, and formal contractor quotations . . . to

⁵⁸ Claims-made policies cover claims first made during the policy period. *See, e.g., Hoechst Celanese Corp. v. Certain Underwriters at Lloyd's London*, 656 A.2d 1094, 1095 (Del. 1995) (“Claims-made policies provide coverage only where the underlying claim is first made, in writing, during the policy period. Therefore, the initial focus under a claims-made policy is on the date of the first written assertion of the claim, rather than the date of the injury or damage alleged within that claim.”). Many PLL policies contain language similar to the following: “Many of the coverages [provided herein] contain claims-made-and-reported requirements. Please read carefully.” Howard, *supra* note 23, at 962.

⁵⁹ Howard, *supra* note 23, at 959.

⁶⁰ *Id.*

⁶¹ *Id.* “Cleanup cost cap coverage generally excludes coverage for bodily injury, property damage, third-party liability, fines, penalties, and policyholder noncompliance for criminal acts,” the very coverage offered through PLL policies. *Id.* at 960.

⁶² *Id.* at 959-60 (“Cleanup cost cap insurance coverage is first-party coverage designed to protect the policyholder against possible cost overruns in the course of performance of planned environmental remediation projects.”).

⁶³ *Id.* at 960.

⁶⁴ *Id.*

⁶⁵ *Id.*

underwrite” policies.⁶⁶ These procedures aid parties in accumulating the information necessary for the policyholder to determine what, specifically, must receive coverage and the insurer to underwrite the risk accurately.⁶⁷

However, the nature of environmental contamination makes accuracy only a roughly achievable goal, despite hefty investments in due diligence.⁶⁸ “Each environmental cost is the product of probability and consequence,” requiring the use of mathematical models to eliminate bias and to account for the interrelationship between numerous environmental factors.⁶⁹ Ultimately, these models achieve estimates of liability, rendering it necessary for developers to offset the risks that “cannot be accurately determined” via insurance.⁷⁰ Those environmental costs that parties cannot anticipate in advance are those best suited for environmental insurance.⁷¹

Such uncertainty, combined with the size of potential liabilities, means that both developers and insurers have a clear incentive to negotiate the terms of environmental insurance policies carefully.⁷² Since absolute accuracy regarding the risks is difficult to obtain on the contaminated site, accuracy must exist in the policy’s negotiated terms to circumscribe the unknown costs on either side.⁷³ Unlike property, casualty, and liability insurance, which insurers sell in standard form, the terms of environmental policies are often rigorously negotiated.⁷⁴

The cost of accumulating the relevant information and negotiating the terms of the policy is the first major expense associated with purchasing

⁶⁶ See e.g., *Frazer Exton Dev., LP v. Kemper Env'tl., Ltd.*, No. 03 Civ. 0637, 2004 WL 1752580, at *1 n.5 (S.D.N.Y. July 29, 2004) (citations omitted).

⁶⁷ See Anderson, *supra* note 50, at 137.

⁶⁸ See *id.* at 101.

⁶⁹ *Id.* at 137.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*; Video Webcast: Tips for Negotiating & Using Env'tl. Ins. Policies & Selected Case Law Concerning Claims (ALI-ABA 2008) available at http://www.ali-aba.org/index.cfm?fuseaction=online.mp3downloads_detail&segmentid=14764 [hereinafter ALI-ABA Video Webcast].

⁷³ See Anderson, *supra* note 50, at 137 (“Environmental insurance is a particularly effective tool for transferring low-probability, high consequence risk Moreover, thoughtful use of environmental insurance can effectively reduce the impact of the risks transferred under the policy to a financial consequence defined by the premium cost and applicable deductibles.”).

⁷⁴ See ALI-ABA Video Webcast, *supra* note 72.

environmental insurance.⁷⁵ Because of the high financial stakes and the degree of uncertainty, the party purchasing the insurance will often engage a team of professionals to assist in the negotiations, including lawyers, environmental consultants, insurance brokers, and high-level representatives of the insured.⁷⁶ The cost of this upfront risk assessment and negotiation generally benefit the policyholder.⁷⁷ Although environmental insurance policies prior to negotiations may not provide significant transfer of environmental risks, “careful manuscripting of endorsements to integrate coverages between policies and to integrate insurance into the overall transaction can provide a very effective means of allocating risk.”⁷⁸ As a result, properly drafted environmental insurance may be the most certain and successful means of defining environmental risk.⁷⁹

The high costs associated with environmental insurance policies do not end with the upfront costs of risk assessment and representation for policy negotiations.⁸⁰ The second set of costs involves the actual purchase price of the policy.⁸¹ Premiums for PLL policies, for example, can start at between \$5,000 and \$15,000 per year with a minimum deductible between \$5,000 and \$10,000 dollars per incident.⁸² Policy limits for PLL policies range from \$1 million to \$100 million, with higher limits frequently possible through negotiation.⁸³ Similarly, Cost Cap policies often carry hefty premiums and deductibles.⁸⁴ Typically, a minimum premium for a Cost Cap policy will run between eight and fifteen percent of a site’s estimated clean-up costs with a policy limit of twice the estimated clean-up cost.⁸⁵ Insurers will generally not provide coverage for cleanups estimated to cost less than \$1 million, but will provide coverage limits as high as \$300 million depending on whether reinsurance is available.⁸⁶ In addition to paying premiums, policyholders are responsible for paying a “self-

⁷⁵ *See id.*

⁷⁶ *Id.*

⁷⁷ *See* Anderson, *supra* note 50, at 103.

⁷⁸ *Id.* at 137.

⁷⁹ *Id.*

⁸⁰ *See* DeMeo et al., *supra* note 39, at 77.

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *See id.* at 83.

⁸⁵ *Id.*

⁸⁶ *See* DeMeo et al., *supra* note 39, at 83.

insured retention” (SIR) before the insurer will begin paying.⁸⁷ The SIR functions as the policy’s deductible, and is equal to the estimated clean-up cost of the property plus ten to thirty percent “to eliminate any incentive for underbidding and to account for losses almost certain to occur ...”⁸⁸ Thus, when a policyholder purchases Cost Cap insurance, he agrees to pay premiums, all estimated clean-up costs, and a certain amount of costs above that estimate before the insurer begins covering unanticipated costs.⁸⁹ Environmental insurance policies thus require substantial contributions from policyholders both at the time of purchase and whenever a claim arises.⁹⁰

With such high stakes, a third cost associated with environmental insurance policies may be litigation. But, even though environmental insurance has been available in some form since the late 1970s,⁹¹ litigation has been infrequent.⁹² Until recently, few cases have gone to trial, perhaps because, with such high stakes, the parties prefer to settle disputes out of court.⁹³ Another explanation for the lack of case law is that the costly, team-based negotiations described above may reduce both the need and the incentive to litigate.⁹⁴ On one hand, thorough negotiations generally mean that parties have brought all available information to the table, allowing the insurer the opportunity to underwrite accurately and the potential policyholder the opportunity to carefully assess and define the specific risks that require coverage.⁹⁵ On the other hand, negotiations reduce the incentive of either party to commence litigation because they effectively create (or demonstrate) equal bargaining power between the parties, thereby rendering judicial treatment of the policies uncertain.⁹⁶

Generally speaking, the common law doctrine of *contra proferentem* governs all ambiguities in insurance policies when coverage is litigated, dictating that ambiguous terms should be construed against the insurer, who deals in the subject matter routinely and had the benefit of

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *See id.*

⁹⁰ *See id.*

⁹¹ Falini, *supra* note 4, at 95.

⁹² Interview with David Platt, Attorney, Murtha Cullina LLP, in Hartford, Conn. (Oct. 8, 2008) [hereinafter Platt Interview].

⁹³ *Id.*; *see also* Falini, *supra* note 4, at 98.

⁹⁴ *See* ALI-ABA Video Webcast, *supra* note 72.

⁹⁵ *See* Falini, *supra* note 4, at 98.

⁹⁶ *See* ALI-ABA Video Webcast, *supra* note 72.

drafting the terms.⁹⁷ However, where parties individually negotiate terms and have relatively equal bargaining power, as with environmental insurance policies, the rationale for applying *contra proferentem* may be diminished.⁹⁸ Lack of knowledge as to how courts will treat environmental insurance policies reduces the incentive for either the insurer or the insured to bring a dispute to trial.⁹⁹ Thus, up until recently, few cases involving disputes over environmental insurance have made it to court.¹⁰⁰

Despite this apparent reluctance to litigate, courts have heard the first batch of cases involving environmental insurance policies in recent years.¹⁰¹ One increasingly litigated issue involves allocation and priority of coverage.¹⁰² A second litigious issue involves the known risk doctrine, which dictates that an insurer should not be obliged to provide coverage for a liability that the policyholder knew about or reasonably should have foreseen.¹⁰³ Section III discusses the allocation and priority of coverage and provides a framework for interpreting environmental insurance policies. Section IV analyzes the issue of “known conditions” and argues that *contra proferentem* should be applied to environmental insurance policies to encourage insurers to assume an information-forcing role during negotiations.

III. ALLOCATION AND PRIORITY OF COVERAGE LITIGATION

Environmental insurance policies generally consist of a standard form policy and numerous, individually negotiated endorsements modifying the standard terms.¹⁰⁴ Policyholders may have multiple environmental insurance policies to cover risks associated with different aspects of their operations; each of these policies may contain exclusions intended to eliminate coverage of risks that are not insured or that are insured against by other types of policies.¹⁰⁵ Thus, complicated relationships may exist within a policy and also between multiple types of environmental insurance policies, each with different focuses, exclusions,

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *See id.*

¹⁰⁰ *Id.*; *see also* Platt Interview, *supra* note 92.

¹⁰¹ *See* Platt Interview, *supra* note 92.

¹⁰² *See* Howard, *supra* note 23, at 979.

¹⁰³ *See* ALI-ABA Video Webcast, *supra* note 72.

¹⁰⁴ *Id.*

¹⁰⁵ *See* Platt Interview, *supra* note 92.

and individually negotiated endorsements.¹⁰⁶ Broader indemnification agreements and other forms of liability coverage may further complicate coverage, leading policyholders and insurers to dispute issues of allocation and priority of coverage.¹⁰⁷ Furthermore, the opinions and requirements of environmental agencies and regulations may bear upon the interpretation of environmental insurance policies.¹⁰⁸

Given this complex of interrelated obligations, both within a policy and in related agreements, confusion may arise regarding the interpretation of a policy's terms. This section argues that environmental insurance policies must be considered within the context of multiple agreements, and proposes a framework for interpreting these policies based on recent litigation. Under the framework, courts should first determine the policy terms by considering the relationship between a policy's standard form terms and endorsements, which may modify the terms in the standard contract. Second, courts should evaluate the policy's exclusions to determine the intended scope of coverage. While this analysis is done primarily on the basis of the policy's language, consideration of other environmental insurance policies held by the same insured may clarify the intended scope of each agreement assuming the parties sought to avoid coverage overlap during drafting. Third, courts should consider broader business and indemnification agreements, if any, between the insured and other parties working on the contaminated site covered by the policy. Fourth and finally, courts should consider how the policy treats agency preferences and regulatory requirements in determining the application of the policy terms.

A Pennsylvania case, *URS Corporation v. Tristate Environmental Management Services*, illustrates the first element of the framework: determining the policy's terms by assessing how the individually-negotiated endorsements modify the "standard form" coverage.¹⁰⁹ This step helps determine liabilities covered by the environmental insurance policy, such as cost overruns, harms to people or property resulting from environmental contamination, or harms to people or property arising from negligence in the remediation process.¹¹⁰

¹⁰⁶ See Howard, *supra* note 23, at 957-58.

¹⁰⁷ See *infra* pp. 20-22.

¹⁰⁸ See *id.* at 23-24.

¹⁰⁹ See, e.g., *URS Corp. v. Tristate Env'tl. Mgmt. Servs., Inc.*, No. 08-154, 2008 WL 2944875, at *5 (E.D. Pa. July 28, 2008).

¹¹⁰ See *id.* at *1, 2, 4, 5.

In *URS Corporation*, URS purchased a PLL policy to cover liabilities resulting from an environmental remediation project that included significant drilling.¹¹¹ The policy's standard form contained a broad exclusion for "professional services," which exempted coverage for harms caused by negligence during the remediation project to people or property.¹¹² During the course of drilling, the corporation damaged cables belonging to Amtrak and was sued for negligence to recover appropriate damages.¹¹³ When URS requested indemnification and defense under its PLL policy, the insurer disagreed with URS about whether an endorsement modified the broad standard form exclusion of professional services from coverage.¹¹⁴

In reaching its decision, the court determined that the policy could be divided into three parts: the policy declarations, the portion with eight individually negotiated endorsements, and the standard form.¹¹⁵ The standard form included a broad exclusion for "professional services," excluding coverage for "any professional service, including but not limited to... [s]upervision, inspection, construction or project management, quality control or engineering services" (emphasis omitted).¹¹⁶ But, in one of the individually negotiated endorsements, the insurer agreed to provide coverage for professional and contracting services narrowly defined to include certain environmental consulting services and certain environmental drilling.¹¹⁷ The court held that the narrower definition in the

¹¹¹ *See id.* at *1.

¹¹² *Id.* at *2.

¹¹³ *Id.* at *1.

¹¹⁴ *Id.* at *2-3.

¹¹⁵ *See URS Corp.*, 2008 WL 2944875, at *1 (emphasis omitted).

¹¹⁶ *Id.* at *2. The professional liability exclusion from general liability coverage, in pertinent part, reads as follows: "'Bodily injury' or 'property damage' arising out of the rendering or failure to render *any professional service, including but not limited to* (1) The preparing, approving or failure to prepare or approve maps, drawings, opinions, recommendations, reports, surveys, change orders, designs or specifications; (2) *Supervision, inspection, construction or project management, quality control or engineering services . . .*" *Id.*

¹¹⁷ *Id.* at *1-2. "This Policy applies to a 'claim' based upon or arising out of the following 'Professional Services' or 'Contracting Services' only" It then lists "professional services" and "contracting services," defining them as "environmental consulting services" and "environmental drilling and probing activities," respectively. *Id.* at *2.

endorsement should be applied in this instance and that the insurer should provide indemnification.¹¹⁸

The court's rationale demonstrates the importance of considering how a policy's endorsements modify standard form provisions.¹¹⁹ Courts should consider what terms the endorsements are meant to modify and read that modification into the standard form.¹²⁰ Because the endorsements represent the individually-negotiated component of the policy, they take precedence over other terms, including broad exclusions, within the standard form.¹²¹ Thus, endorsements may indicate that the policyholder may be indemnified for environmental harms—or, as in this case, accidental or negligent damage to people or property—that would otherwise be excluded within broad and general standard form provisions.¹²² Identifying the scope of a policy's coverage for environmental or negligent harms thus relies upon careful consideration of how endorsements modify standard form coverage.¹²³

Another case, *Denihan Ownership Co. v. Commerce and Indus. Ins. Co.*, illustrates the second step within the framework for interpreting environmental insurance policies.¹²⁴ This step entails consideration of the scope of policy exclusions, and potentially implicates the interplay between multiple environmental insurance policies held by the same insured.¹²⁵ In *Denihan Ownership*, the company purchased a PLL policy to supplement a Cost Cap policy purchased in connection with the remediation of several parcels of land containing low-rise commercial property, such as a parking garage, a car repair shop, and a dry cleaner.¹²⁶ The insured purchased the insurance policies based on due diligence performed by an environmental consultant to provide estimates for the land's remediation.¹²⁷ During

¹¹⁸ *Id.* at *3. In fact, the court held that the policy's definition of "professional services" was ambiguous and construed the terms in favor of the insured. *Id.* at *3, 4. Thus, the court applied "contra proferentem" in the case although the parties were both, arguably, sophisticated and the policy entailed individual negotiations. See *URS Corp.*, 2008 WL 2944875, at *3; see also *infra*, Part II. A.

¹¹⁹ See *URS Corp.*, 2008 WL 2944875, at *5.

¹²⁰ See *id.*

¹²¹ See *id.*

¹²² See *id.* at *4-5.

¹²³ See *id.* at 4.

¹²⁴ See, e.g., *Denihan Ownership Co., v. Commerce & Indus. Ins. Co.*, 830 N.Y.S.2d 128, 129-30 (N.Y. App. Div. 2007).

¹²⁵ See, e.g., *id.* at 129.

¹²⁶ *Id.*

¹²⁷ *Id.*

remediation, the insured accrued expenses beyond the Cost Cap policy's coverage limit. The insured claimed that this excess expense should be covered under the supplemental PLL policy.¹²⁸ The insurer denied this claim.¹²⁹

Ensuing litigation between these parties illustrates the interplay between conditions covered under a Cost Cap policy and a PLL policy purchased by the same insured.¹³⁰ The policyholder claimed that the insurer should be required to pay the excess costs of remediation under the PLL policy, which provided coverage for liabilities arising from "unknown and unidentified conditions."¹³¹ The excess costs, the policyholder further argued, derived from "unknown and unidentified" contamination that the environmental consultants had overlooked, and thus fell within the scope of the PLL policy's coverage.¹³² In contrast, the insurer argued that the "unknown and unidentified" contamination had been contemplated if not specifically identified by the reports the environmental consultants submitted.¹³³ Thus, the insurer urged that the PLL policy, which was not intended to cover the excess of contemplated remediation costs, should not be obliged to pay for the costs of remediating the specific conditions at issue.¹³⁴ Rather, the Cost Cap policy was specifically intended to cover the excess costs of remediation; the fact that the policyholder had accrued excess expenses beyond the Cost Cap policy's limits did not make the PLL policy suddenly applicable to liabilities resulting from excess costs.¹³⁵

Evaluating the language of the PLL policy, and therein considering its relationship to the Cost Cap policy, the court held for the insurer.¹³⁶ The court evaluated the PLL policy's language, noting that it contained a broad exclusion of contamination "arising from" pollution conditions in the environmental consultant's report.¹³⁷ The court held that, because the contamination the insured wanted the PLL supplemental policy to cover was "contemplated," if not expressly listed, in the environmental

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *See Denihan*, 830 N.Y.S.2d at 129.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Denihan*, 830 N.Y.S.2d at 129.

¹³⁷ *Id.* at 130.

consultant's report, the court said it fell within the broad exclusion's scope.¹³⁸

In reaching this decision, the court cited the existence and scope of the Cost Cap policy as evidence of the policy's intended scope. The court noted that the known condition exclusion "was clearly intended to ensure no overlap between the underlying [Cost Cap] policy, which provided coverage for petroleum contamination on the site, and new and different pollution conditions covered by the [PLL] policy."¹³⁹ Thus, even as the court based its decision on the PLL policy's language, it gave a nod to the scope of a sister policy as an interpretive tool in clarifying the intended scope of the policy in question.¹⁴⁰

Indeed, since policies like PLL and Cost Cap insurance are intended to compliment each other,¹⁴¹ each may contain exclusions that broadly eliminate risks insured against in a complimentary policy.¹⁴² The exclusions and scope of coverage in one policy can inform the intended scope of coverage of the other policy.¹⁴³ In interpreting a policy's language, courts may consider the relationship between policies in the same insurance portfolio to reinforce the intended scope of each policy and perhaps resolve ambiguities.¹⁴⁴ Doing so prevents overlap, ensuring efficient coverage and giving force to the parties' original intentions.¹⁴⁵

A third consideration when construing ambiguous environmental insurance policies may entail an assessment of broader indemnification agreements. A 2001 dispute between General Motors (GM) and American Ecology illustrates the complicated relationship between environmental insurance policies and other business agreements held by the same company.¹⁴⁶ GM hired American Ecology, a waste management company, to dispose of some of its hazardous waste.¹⁴⁷ The parties entered into a

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *See infra* Part II.B.

¹⁴² *See Denihan*, 37 A.D.3d at 315.

¹⁴³ *See id.*

¹⁴⁴ *See Denihan*, 37 A.D.3d 314.

¹⁴⁵ *See id.* at 315.

¹⁴⁶ *See Gen. Motors Corp. v. Am. Ecology Env'tl. Servs. Corp.*, No. Civ. A 399CV2625L, 2001 WL 1029519 (N.D. Tex. Aug. 30, 2001).

¹⁴⁷ The predecessor to American Ecology was called Gibraltar. For the purposes of this case, the two companies are the same entity and the court indeed uses the two names interchangeably when referring to the waste management company. *See id.* at *2, n.4.

mutual indemnification agreement, which included a provision that American Ecology would secure PLL coverage and name GM as an additional insured.¹⁴⁸ The purpose of this provision was to ensure that GM would be covered should a toxic tort suit be brought against American Ecology and, by extension, GM.¹⁴⁹ American Ecology purchased PLL insurance, but failed to name GM as an “additional insured” as stipulated in the mutual indemnification agreement.¹⁵⁰ Thus, GM found itself lacking indemnification when several hundred plaintiffs brought a toxic tort suit for improper disposal of GM’s waste and claimed that GM was directly and vicariously liable for American Ecology’s improper actions.¹⁵¹

In response, GM brought a suit against American Ecology primarily to recover several hundred thousand dollars in attorneys fees incurred in defending a declaratory judgment action that the insurer brought seeking subrogation.¹⁵² American Ecology claimed, firstly, that it was not required to indemnify GM under the agreement because the suit involved a “mixed” claim of both direct and vicarious liability which was not stipulated in the contract.¹⁵³ It also claimed that it was excused from its contractual obligation to add GM to the PLL policy because the insurer, Zurich, did not permit the practice of naming “additional insureds” on PLL policies.¹⁵⁴

¹⁴⁸ *Id.*, at *2.

¹⁴⁹ *See id.* Under the indemnification agreement, American Ecology was required to “obtain and maintain all insurance required herein,” including PLL policy with a \$4,000,000 per occurrence combined single limit for personal injury and property damage and an \$8,000,000 annual aggregate limit. *Id.*, at *2, *11. Additionally, American Ecology was required to purchase a CGL with a \$5,000,000 per occurrence combined single limit, and an Automobile Liability insurance policy with a \$5,000,000 per occurrence combined single limit. *Id.*

¹⁵⁰ *Id.*

¹⁵¹ *Id.* For details pertaining to the underlying toxic tort case against American Ecology and GM, see *Virgie Adams v. American Ecology Environmental Services Corp.*, Cause No. 236-165224-96, in the 236th Judicial District Court in Tarrant County, Texas.

¹⁵² *See* Gen. Motors Corp., 2001 WL 1029519, at *8. (“GM contends that it incurred . . . \$505,800.45 in attorneys’ fees and expenses including guardian *ad litem* fees, expert witness fees, joint counsel fees and fees incurred in . . . [the Zurich litigation].”).

¹⁵³ *Id.*, at *5.

¹⁵⁴ *Id.* (noting that Zurich, in fact, does not add clients of principal policyholders as additional insureds on their environmental impairment liability policies because it would “broaden the coverage of the policy to an unacceptable degree”). *Id.*, at *12.

The court rejected American Ecology's arguments regarding its responsibilities under both the mutual indemnification provision and the PLL policy.¹⁵⁵ The court interpreted the company's responsibilities under the mutual indemnification agreement to require indemnification of GM and an obligation to purchase a PLL policy with GM as a named insured, absent notice to GM to the contrary.¹⁵⁶ The court remanded the case for a factual determination of damages GM incurred as a result of American Ecology's failure to name it as an additional insured on a PLL policy.¹⁵⁷

In this case, the court determined a party's responsibility to obtain environmental insurance on the basis of a broader indemnification agreement, thereby illustrating the need for courts to take other business agreements into account.¹⁵⁸ These other agreements may inform the issue of coverage and will, in particular, shed light on the liabilities parties agreed to incur as part of a project.¹⁵⁹ The sheer number of interrelated business agreements may make this process complicated. However, the exercise may frequently be worthwhile considering the immense liabilities that a party left without coverage may face.¹⁶⁰

Finally, courts should consider a fourth element when construing the terms of an environmental insurance policy.¹⁶¹ Unless terms expressly exclude the risk that agency preferences and regulatory requirements may impact the costs a policyholder incurs at a covered site, such costs should be covered under the policy.¹⁶² Because environmental contamination is subject to numerous regulations and is under the auspices of both state and federal agencies, a contaminated site may be subject to more stringent, or simply different, remediation requirements than the parties originally anticipated.¹⁶³ For example, environmental agencies may set new remediation requirements or play a role in choosing the course of site clean-up.¹⁶⁴ As a result, many environmental insurance policies take the future determinations of environmental agencies into account because

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*, at *13. (holding that the only way American Ecology could be excused from naming GM as an additional insured was by providing notice that it was unable to do so within 30 days, but that such notice was not provided in this case).

¹⁵⁷ *Id.*, at *14.

¹⁵⁸ *See Gen. Motors Corp.*, 2001 WL 1029519, at * ____.

¹⁵⁹ *See id.*

¹⁶⁰ *See id.*

¹⁶¹ *See, e.g., Frazer*, 2005 WL 2850247, at *1.

¹⁶² *See, e.g., id.*

¹⁶³ *See, e.g., id.*

¹⁶⁴ *See, e.g., id.*

agency opinions and regulations may directly alter the scope of risk.¹⁶⁵ Litigation may emerge as to whether a policy should cover liabilities arising from changes in the law governing remediation where the policy does not expressly account for this contingency or does so ambiguously.¹⁶⁶

For example, in *Frazer Exton Development v. Kemper Environmental*, Kemper refused an insurance claim under an environmental insurance policy because the U.S. Environmental Protection Agency (EPA) required that the policyholder undertake remediation measures that Kemper maintained were not covered by the policy.¹⁶⁷ The insured, Frazer, argued that the policy included Cost Cap coverage for any remedy the EPA required.¹⁶⁸ The Second Circuit Court of Appeals affirmed the district court's order finding for Frazer, holding that the policy provided broad Cost Cap coverage subject to EPA-selected remedies.¹⁶⁹ The court based its holding on its reading of the policy language, which it held to be unambiguous, but stated that it would have reached the same result even had ambiguity existed.¹⁷⁰ The court noted, "[e]ven if the policy is ambiguous, the outcome is dictated by the principle of interpretation known as *contra proferentem*."¹⁷¹ Thus, the court held that all ambiguities in the insurance policy should be construed in favor of the insured.¹⁷² Moreover, it acknowledged the need for environmental insurance policies to cover liabilities arising from changes in law where the policy does not expressly exclude such risks.¹⁷³

Complicated relationships exist between an environmental insurance policy's standard form and endorsements, complimentary environmental insurance policies, other agreements between parties, and the laws that influence remediation requirements. This complicated landscape creates substantial room for misunderstanding, conflicting information and expectations, and, thus, litigation. Courts must be prepared to navigate these relationships when determining coverage.

¹⁶⁵ See, e.g., *id.*

¹⁶⁶ See, e.g., *id.*

¹⁶⁷ *Frazer*, 2005 WL 2850247, at *1.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*, at *1-*2.

¹⁷¹ *Id.*, at *2.

¹⁷² *Id.*

¹⁷³ *Frazer*, 2005 WL 2850247, at *1.

IV. KNOWN AND UNKNOWN CONDITIONS LITIGATION

Another litigious area relates to the issue of “known condition” exclusions. This section provides background about the role of the “known condition” exclusion in environmental insurance policies. It then details litigation that has emerged over the exclusion, and argues that courts should construe these conditions in a manner consistent with the doctrine of *contra proferentem* so that insurers feel compelled to play an information-forcing role during negotiations. Finally, this section discusses litigation involving claims of misrepresentation of “known conditions” and again argues that placing the burden on the insurer to clearly identify known conditions will reduce claims of misrepresentation by giving the insurer added incentive to seek information during negotiations.

A. AN OVERVIEW OF THE “KNOWN CONDITION” EXCLUSION

Environmental insurance policies typically exclude coverage of pollution liabilities that are known to the insured at the time the policy is purchased.¹⁷⁴ During the risk assessment and negotiation stage of issuing a policy, the insurer has particular incentive to identify, and broadly define, “known conditions” to minimize the scope of future liabilities.¹⁷⁵ Likewise, the insured has the incentive to narrowly define “known conditions,” to ensure coverage for as many liabilities as possible down the road.

To trigger the “known condition” exclusion, specified employees¹⁷⁶ must have known or reasonably foreseen that the pre-existing condition would give rise to a claim under the policy.¹⁷⁷ The term typically excludes from coverage all otherwise covered liabilities “[a]rising from Pollution Conditions existing prior to the Inception Date and known by a Responsible Insured and not disclosed in the application for” this policy or a renewing policy.¹⁷⁸ Through this exclusion, insurers seek to eliminate

¹⁷⁴ See Howard, *supra* note 24, at 973; see also DYBDAHL, *supra* note 7, at 31.

¹⁷⁵ See *infra* Introduction.

¹⁷⁶ DYBDAHL, *supra* note 7, at 31 (“To provide a reasonable degree of protection for the insurer without eliminating all pre-existing conditions, EIL policies commonly exclude only those pre-existing conditions that are known to an individual or a group of designated persons. The exclusion usually limits the list of employees who must have knowledge of pre-existing conditions to (1) those directly responsible for environmental affairs or (2) senior managers.”).

¹⁷⁷ *Id.*

¹⁷⁸ Howard, *supra* note 24, at 973.

coverage where the policyholder anticipated a claim.¹⁷⁹ The goal is thus to avoid moral hazard rather than to eliminate coverage simply because the insurer “should have anticipated” a particular, coverable occurrence.¹⁸⁰

The “known condition” exclusion implicates the common law “known loss doctrine,” which stands for the principle that an insurer should not be obliged to assume losses known or reasonably knowable to the policyholder, but not to the insurer, at the time a policy is purchased.¹⁸¹ This doctrine, in turn, derives from the “fortuity principle” which states that all risks or losses insured against must be fortuitous or contingent.¹⁸² Lack of contingency necessarily negates insurance coverage given that insurance is, at its fundamental level, a “method of managing risk by distributing it among numbers of individuals or enterprises” where risk means “the possibility of injury or loss.”¹⁸³ Where a loss is “known,” a “possibility” of injury or loss is no longer possible, but certain, and insurance is thus no longer appropriate.¹⁸⁴

Though uncontroversial in itself, the fortuity principle resulted in litigation when applied to CGL pollution coverage suits that predated separate environmental insurance coverage.¹⁸⁵ These suits led to divergent applications between courts and substantial confusion.¹⁸⁶ Under CGL policies, the difficulties in application arose because of the information asymmetry that often occurs when purchasing or issuing an insurance policy.¹⁸⁷ An applicant might seek to transfer a loss he knows has already occurred or is likely to occur to an insurer that believes the loss is still a contingent event.¹⁸⁸ Obliging an insurer to pay for an event that was not

¹⁷⁹ DYBDAHL, *supra* note 7, at 31.

¹⁸⁰ *Id.*

¹⁸¹ Howard, *supra* note 24, at 973.

¹⁸² See Richard L. Freuhauf, Note, *The Cost of Knowledge: Making Sense of “Nonfortuity” Defenses in Environmental Liability Insurance Coverage Disputes*, 84 VA. L. REV. 107, 112 (1998).

¹⁸³ *Id.* at 111 (internal citations omitted).

¹⁸⁴ See *id.* at 118. (“[T]he known loss doctrine is the most straightforward application of the fortuity principle among the three non-fortuity defenses.”).

¹⁸⁵ See *id.* at 110.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.* at 112.

¹⁸⁸ A frequently cited case on this point is *Summers v. Harris*, 573 F.2d 869 (5th Cir. 1978), in which the insured attempted to claim indemnification under a flood insurance policy that he purchased after floodwaters had reached within a few feet of his home. The court barred coverage under the loss-in-progress rule. See *id.* at 115, n.37. Another classic example of this danger is when an insured

actually contingent would disregard the bargain the parties struck, which was to exchange a certain premium for the chance that a loss might occur later.¹⁸⁹ Hence, the fortuity principle is necessary to ensure that the policyholder does not exploit the information asymmetry to his advantage.¹⁹⁰

Environmental insurance policies are no less prone to abuse concerning information asymmetry and thus run-ins with the fortuity principle than CGL or any other type of insurance policy.¹⁹¹ Typical cases surrounding the known conditions exclusion fall into two categories.

In the first category, the insurer argues that a claim brought by the insured was a “known” condition, thus exempt from coverage. This section argues that courts should apply a narrow definition of “known condition” through the doctrine of *contra proferentem* where the exclusion is ambiguous and the insurer is in a superior position to play an information-forcing role during due diligence and negotiations.

In the second category, the insurer acknowledges that the liability was “unknown,” as defined by the policy, but argues that the insured in fact knew about the liability and misrepresented the facts (and thus the risk) to the insurer.¹⁹² This section again argues that courts should give deference to the policyholder because of the difficulty of identifying material facts without the benefit of hindsight. Doing so would place the burden on the insurer to request all relevant information during negotiations and bring greater clarity to cases involving misrepresentation. However, in both types of dispute, courts may be justified in limiting their application of *contra proferentem* where the bargaining power and familiarity with environmental risks is relatively equal between the parties.¹⁹³

attempts to collect on a fire insurance policy that he purchased after learning his property was destroyed by fire. *Id.* at 112.

¹⁸⁹ *See id.* at 112.

¹⁹⁰ *Id.* (“The potential for a policyholder to exploit the information asymmetry inherent in the insurance contract by fraudulently seeking indemnification for a loss that the carrier did not bargain to insure is the rationale for the ‘fortuity’ requirement in all insurance contracts, as well as for the doctrines of concealment and misrepresentation found in general contract law.”)

¹⁹¹ *See id.*

¹⁹² *See, e.g.,* *Goldenberg Dev. Corp. v. Reliance Ins. Co. of Ill.*, No. CIV. A. 00-CV-3055, 2001 WL 872944 (E.D. Pa. 2001) (discussing insurer’s argument that insured allegedly did not give insurer engineering reports saying that there was substantial underground trash that would result in significant remediation costs).

¹⁹³ RICHARD A. LORD, 11 WILLISTON ON CONTRACTS § 32:12 (4th ed. 2008).

B. LITIGATION ABOUT THE DEFINITION OF A "KNOWN CONDITION"

Disagreement over whether a condition is "known" at the time a policy was purchased arises because of the difficulty in defining environmental risks, given the uniqueness and complexity of conditions on any given property.¹⁹⁴ Early in the development of the environmental insurance market, experts urged insurers to develop a clear set of standards for evaluating environmental risks.¹⁹⁵ While insurers have certainly heeded this recommendation, as evidenced by the substantial data collection required during the negotiation of an environmental insurance contract, obtaining "clear" standards is a lofty goal considering the context.¹⁹⁶ When an insurer issues a policy for, say, car insurance, it may collect information from the insured pertaining to age, location, demographics, car type and age, and more. This data can be used to facilitate the underwriting process, because the insurer can compare it to reams of like-data and determine relative risks.

In contrast, when an insurer negotiates an environmental insurance policy, it is assessing risk in a relative vacuum.¹⁹⁷ Certainly, it may collect large quantities of data from the insured about the site to determine what, exactly, represents a risk on that location.¹⁹⁸ But, no comparable sites, with the same soil, water tables, and use history, necessarily exist.¹⁹⁹ Although, "[g]eneral procedures for dealing with contaminated site evaluation and remediation have been developed . . . the wide variety of natural site conditions and release characteristics have made it difficult to establish useful databases" to assist actuaries in evaluating the risk being transferred.²⁰⁰ Absent comparable sites, insurers have difficulty assessing

¹⁹⁴ See Anderson, *supra* note 50, at 137; see also David E. Langseth, *Valuing Environmental Remediation Liability Transfers*, 20 ENVTL. CLAIMS J. 2, 2-3 (Jan. 2008).

¹⁹⁵ See, e.g., Paul K. Freeman & Howard Kunreuther, *The Roles of Insurance and Well-Specified Standards in Dealing with Environmental Risks*, 17 MANAGERIAL AND DECISION ECON. 517 (1996).

¹⁹⁶ See, e.g., *id.*

¹⁹⁷ See Langseth, *supra* note 194, at 2-3.

¹⁹⁸ See *id.*

¹⁹⁹ See *id.*

²⁰⁰ See *id.* (noting that "[t]his situation has led some insurance companies to adopt site-specific approaches, of varying degrees of sophistication, for assessing [risk values] and created considerable variability in pricing methods for remediation cost cap insurance")

what other conditions might exist and how great the risk might be for this particular site verses any other.²⁰¹

Facing this relative actuarial void, insurers wish to construe “known” risks broadly, implicating anything alluded to in initial surveys and data collection.²⁰² Meanwhile, policyholders typically define the term “known conditions” literally, referring to specific contamination or risks clearly identified, defined, and labeled on a site map at the time of the initial surveys and data collection.²⁰³ These divergent definitions of “known conditions” have lead to litigation construing the meaning of the exclusion in different situations.

For example, in *Denihan Ownership Co.*, discussed supra,²⁰⁴ the policyholder and the insured were essentially litigating the breadth of the definition of a “known condition” in addition to the issue of whether the PLL policy or the Cost Cap policy provided the appropriate coverage.²⁰⁵ Whereas the policyholder claimed that storage tanks not specifically identified in the environmental consultant’s reports should be considered unknown conditions, the insurer argued that the possibility of discovering additional storage tanks had been contemplated by the report and were thus excludable known conditions.²⁰⁶ In this case, the court agreed with the insurer, adopting a broad definition of “known conditions.”²⁰⁷ The holding suggests that, because additional conditions similar to those already discovered were reasonably foreseeable to the insured and the insurer, they may be deemed “known” for the purposes of the policy.²⁰⁸

In contrast, the court in *Chambliss v. Commerce and Industry Insurance Company* refused to adopt a broad definition of “knowledge,” holding that knowledge should be handled as an issue of fact.²⁰⁹ This holding leaves open the possibility that a narrow, technical definition of knowledge will be applied in some cases. In this case, Chambliss owned property with underground storage tanks.²¹⁰ Inspectors of the property told Chambliss that they suspected a leak from one of the storage tanks and

²⁰¹ See *id.*

²⁰² See *id.* at 204.

²⁰³ See, e.g., *Denihan*, 37 A.D.3d 314.

²⁰⁴ See *supra* notes 119-128 and accompanying text.

²⁰⁵ See, e.g., *Denihan*, 37 A.D.3d at 315.

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.*

²⁰⁹ See *Chambliss Ltd. v. Commerce & Indus. Ins. Co.*, No. 06-61202-CIV-JOHNSON, 2007 U.S. Dist. LEXIS 77664 *16 (S.D. Fla. Oct. 18, 2007).

²¹⁰ *Id.*, at *2.

recommended that Chambliss seek laboratory analysis for confirmation.²¹¹ Before receiving the laboratory results, Chambliss purchased storage tank third-party liability and Cost Cap coverage, stating on the application questionnaire that no known conditions—that is, contamination from the storage tanks—existed on the property.²¹² When laboratory reports confirmed that one of the storage tanks was leaking, Chambliss submitted a claim to its insurer, which denied coverage on the basis that Chambliss had misrepresented what known conditions were on the property when it applied for coverage.²¹³

In the subsequent litigation, Chambliss argued that coverage for the clean-up hinged on “its knowledge of a confirmed release . . . at the time of applying for that coverage.”²¹⁴ The company urged that “only an investigation and confirmation of a release can elevate a pollution condition to a confirmed release.”²¹⁵ Since the laboratory results had not confirmed a release at the time Chambliss applied for coverage, the company argued that it did not misrepresent its knowledge of pollution conditions.²¹⁶ The insurer, in turn, argued that knowledge under the policy included a reasonable expectation of a pollution condition, which should have had because of the inspectors recommendation to obtain additional testing.²¹⁷

The court ultimately declined “to issue summary judgment on the issue of knowledge.”²¹⁸ However, the court might have more accurately held that it declined to issue summary judgment on the *definition* of knowledge—which was really the point in dispute. The parties did not disagree over the relevant facts, but over whether those facts gave rise to “knowledge” within the meaning of the policy, which included a reasonable expectation of a pollution condition within its definition.²¹⁹

²¹¹ *Id.*

²¹² *Id.*, at *3.

²¹³ *Id.*, at *4.

²¹⁴ See Chambliss, 2007 U.S. Dist. LEXIS 77664, at *10.

²¹⁵ *Id.*

²¹⁶ *Id.*, at *10-*12.

²¹⁷ *Id.*, at *14.

²¹⁸ *Id.*, at *15.

²¹⁹ See *id.* (“Exclusion A states: ‘[T]his insurance does not apply to claims: arising from Pollution Conditions existing prior to the inception of the Policy and

Taking the definition of the policy, the court might have asked: could the company have reasonably expected the laboratory tests to come back positive for contamination from the storage tanks given the findings of the inspector prior to applying for the insurance policy? Because the court left the issue of knowledge as a factual determination subject to ambiguity, it refused to issue a holding as to whether the definition of known condition should be construed narrowly or broadly.²²⁰

Although the facts of this case suggest that Chambliss was relying on a technicality to avoid liability for a foreseeable future risk, the court might have been justified in adopting a narrow definition of “knowledge.” A narrow definition of a known condition would be consistent with the judicial doctrine of *contra proferentem*, which states that all ambiguities in a contract should be interpreted against the insurer.²²¹ The general justification for *contra proferentem* is that insurers had the benefit of drafting the document, and thus should not receive any benefit from ambiguous terms they incorporated.²²² This justification holds less force with environmental insurance policies because they are often rigorously negotiated by both sides.²²³ Indeed, as previously discussed, it is uncertain whether this doctrine is applicable in the environmental insurance context because they have negotiated components in addition to the standard form.²²⁴

However, *contra proferentem* may be justified in many environmental insurance cases where the policyholder is not a repeat player, does not hold a portfolio of contaminated sites, and may lack the expertise necessary to identify material information that the insurer fails to request. Insurers typically are repeat players in issuing environmental insurance and therefore have an advantage in understand the risks of environmental remediation over policyholders that are relative novices. While some policyholders may be able to spread their environmental risks across a portfolio of brownfields, insurers often have the unique advantage of being able to spread risk across many sites. Moreover, insurers may

not disclosed in the application for the Policy, if the Insured knew or *reasonably could have expected* that such Pollution Condition could give rise to a Claim, Corrective Action or Cleanup.”) (emphasis added).

²²⁰ See *id.*

²²¹ See Waeger, *supra* note 73.

²²² LORD, *supra* note 194, §32:12.

²²³ *Id.*; see also, DeMeo, *supra* note 40.

²²⁴ However, the Second Circuit has applied it in this context, creating persuasive precedent for other jurisdictions. See *Frazer*, 2004 WL 1752580, at *2.

have far more knowledge of brownfields generally because of their status as repeat players issuing coverage for many sites at any given time. As a result, insurers are better able to identify uncertainty when negotiating a policy. Their superior ability to know what questions to ask about a site and what uncertainty remains even after the questions have been answered justifies placing pressure on them to identify known conditions as clearly and narrowly in the policies they issue. Given that uncertainty is inevitable, clear drafting of known conditions will at least encourage the highest quality risk assessment and potentially avoid unnecessary litigation due to ambiguity. Litigation about knowledge of a pre-existing condition would thus become limited to cases involving misrepresentation on the part of the policyholder. Application of *contra proferentem* in this context may be less justified where the bargaining power and familiarity with environmental sites is relatively equal between the parties, such as where the policyholder has a portfolio of properties and routinely purchases environmental coverage.

C. THE KNOWN CONDITION EXCLUSION AND MISREPRESENTATION DISPUTES

The second category of “known condition” litigation contains misrepresentation cases. In such cases, one party fails to disclose information that is material to the decision to enter into the policy, but that is not otherwise reasonably ascertainable by the other party.²²⁵ The contract law principle that dictates misrepresentation and concealment void contract obligations also applies to insurance policy misrepresentation cases.²²⁶ To prevail in court on a denial of coverage because of misrepresentation, an insurer must prove that: 1) the representation was untrue or misleading, 2) it was material to the risk transferred, and 3) it was relied upon by the insurer in writing the policy at an agreed-upon premium.²²⁷

The facts of *Goldenberg Development Corporation v. Reliance Insurance Company of Illinois* perfectly illustrate the relationship between

²²⁵ Freuhauf, *supra* note 182, at 112.

²²⁶ *Id.* For a discussion of the extent to which insurance policies are subject to general rules of contract interpretation, see James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995 (1992).

²²⁷ Freuhauf, *supra* note 182.

“known conditions” and misrepresentation.²²⁸ In this case, Goldenberg sought summary judgment regarding whether Reliance had breached a Cost Cap policy purchased to protect against unforeseen remediation costs for a number of Goldenberg’s development sites.²²⁹ Reliance’s underwriters granted a policy extension for the site in question, which was purchased after the issuance of the initial policy.²³⁰ They did so after Goldenberg provided them with a summary report of the land’s conditions that indicated “no further action” was needed to remedy any problems regarding construction debris, woodchips, and chemicals found in the soil.²³¹

After the insurer extended the policy to cover the site, however, Goldenberg performed additional environmental review and discovered significant “solid waste,” including tires, telephone poles, and appliances, which required expensive remediation.²³² Goldenberg filed a claim under its environmental insurance policy that Reliance denied on the basis of the policy’s “known conditions” exclusion.²³³ The term excluded coverage for losses arising from conditions that pre-dated the policy and known to Goldenberg employees responsible for environmental affairs, unless “all material facts relating to the pollution conditions were disclosed to [the insurer] prior to the inception of this Policy.”²³⁴ In this instance, Goldenberg had disclosed a summary report, but not two reports with further detail, which were cited in the summary but not fully provided to Reliance.²³⁵

Reliance claimed that Goldenberg’s failure to disclose these reports constituted misrepresentation because they contained evidence that suggested additional, costly remediation was necessary.²³⁶ Goldenberg countered that the reports had been appropriately disclosed because they were expressly cited in the summary report, and that Reliance could have asked to see them had it needed more information to effectively underwrite

²²⁸ *Goldenberg Dev. Corp. v. Reliance Ins. Co.*, No. 00-CV-3055, 2001 U.S. Dist. LEXIS 12870 (E.D. Pa. May 15, 2001) [hereinafter *Goldenberg I*].

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ *Id.*

²³² *Id.*

²³³ *Id.*

²³⁴ *Goldenberg I*, *supra* note 233.

²³⁵ *Id.*

²³⁶ *Id.*

the policy extension.²³⁷ Goldenberg further argued that the detail about the debris contained in the two reports had been sufficiently integrated into the summary, which referred to the presence of “trash” and thus contained language that unambiguously encapsulated the debris eventually uncovered.²³⁸

Ultimately, the court denied summary judgment to the insurer, Reliance, holding that genuine issues of material fact existed regarding whether the details contained in the reports, namely the presence of small-scale trash on the property, were relevant to the underwriting decision and barred coverage because they were not disclosed.²³⁹ The court also rejected Reliance’s request for summary judgment under the known loss doctrine, holding that there was a genuine issue of material fact as to whether Goldenberg could reasonably have foreseen the costs incurred for the cleanup based on the additional reports which suggested relatively less expensive remediation measures than were ultimately required.²⁴⁰

The facts of this case and its subsequent appeal²⁴¹ reveal the difficulty in determining the materiality of information where there is at once a flood of facts and an inability to know what those facts signify in the big picture.²⁴² Parties may have plenty of information on a property and

²³⁷ *Id.* Goldenberg also argued that the reports in question were immaterial to the claim under the policy because they did not identify the larger solid waste items and recommended a remediation technique that was significantly less expensive than what was ultimately required. *Id.*

²³⁸ *Id.*

²³⁹ *Id.*, at *2. (The existence of smaller-scale trash may or may not have been material to the policy extension, since the possibility of additional cost may or may not have influenced defendant’s determination of the premium, or the decision to issue the policy extension in the first place. When, as here, reasonable minds can differ on the question of the materiality of a fact, materiality is a question for the fact-finder, rather than a question of law for the court and summary judgment is inappropriate.).

²⁴⁰ Goldenberg I, *supra* note 233, at *7 (applying the standard, “The ‘known loss’ doctrine precludes insurance coverage of a loss when the insured knew or reasonably should have known of a likely exposure to losses which would reach the level of coverage.”)

²⁴¹ See *Goldenberg Dev. Corp. v. Reliance Ins. Co. of Ill.*, No. Civ. A. 00-CV-3055, 2001 WL 872782 (E.D. Pa., June 26, 2001) (denying appeal of summary judgment because affidavit from underwriter stating that she “would have wanted to see the information contained in the [undisclosed] reports” does not establish that the information was material to the policy as a matter of law). [hereinafter *Goldenberg II*].

²⁴² See *Goldenberg I*, *supra* note 233; see also *Goldenberg II*.

even information pertaining to a hypothetical future claim, but limited means to sort out what will eventually be material and what will remain irrelevant.²⁴³ Thus, what is “known” has a shifting form—knowledge of facts that will eventually be relevant to a future claim becomes different from knowledge that the future claim is probable.²⁴⁴ As in *Goldenberg*, knowledge that small trash exists could seem irrelevant until one knows that there is also large trash on the site, which suddenly makes the small trash a clue to the unknown bigger problems.²⁴⁵ Absent hindsight, it is hard to know whether the knowledge of the small trash would meet the materiality test by influencing an insurer’s decision to issue a policy, evaluate the degree and character of risk on the site, and determine an appropriate premium.²⁴⁶ The question thus becomes whether hindsight should be allowed to influence a court’s evaluations of what undisclosed known facts are material.

An almost identical dispute to *Goldenberg* arose in *Technology Square*, again illustrating the fine line between misrepresenting known information and not recognizing the relevance of facts.²⁴⁷ In this case, United National Insurance Company (UNIC) alleged that a policyholder, Technology Square, misrepresented material facts in an application for pollution liability insurance to cover a piece of property with a history of “heavy industrial” use, first as a soap factory, then as a hose factory, and lastly a gas station.²⁴⁸ Technology Square provided UNIC with a report chronicling this history.²⁴⁹ On the policy application questionnaire, Technology Square referred to the report in response to a question asking whether it was “aware of any circumstances which may reasonably be expected to give rise to a claim under this policy?”²⁵⁰

Other insurers, with the same report and similar applications, either refused to issue a policy for the site or would do so only for a very high premium.²⁵¹ For example, an AIG Environmental underwriter described the site as “pretty gnarly” and would not provide coverage out of concern

²⁴³ *See id.*

²⁴⁴ *See id.*

²⁴⁵ *See id.*

²⁴⁶ *See* *Goldenberg I*, *supra* note 233.

²⁴⁷ *Tech. Square, LLC v. United Nat’l Ins. Co.*, Civil Action No. 04-10047-GAO, 2007 WL 534450 (D. Mass. Feb. 15, 2007).

²⁴⁸ *Id.*

²⁴⁹ *Id.*

²⁵⁰ *Id.*, at *5.

²⁵¹ *Id.*

for “the amount of contamination on the site.”²⁵² Likewise, a Kemper Environmental underwriter expressed concern about the potential environmental issues and gave a high premium quote because, absent additional investigation, he would be issuing the insurance using a “cross your fingers technique.”²⁵³

UNIC, however, extended insurance to Technology Square for “significantly” less than other offers.²⁵⁴ At no point did UNIC request additional information about the level of environmental damage or the likelihood of significant remediation becoming necessary.²⁵⁵ Yet, when presented with a claim for the overrun of costs for remediating the property, UNIC denied the claim, stating that coverage was limited by a “known conditions” exclusion and that Technology Square had failed to turn over material information—namely, internal documents discussing the due diligence report handed over to UNIC—when applying for the insurance.²⁵⁶ Technology Square argued that the full due diligence report had been disclosed and that the contents of the report were “coextensive” with their knowledge of the material facts about the property’s condition. It further argued that UNIC “was capable of deriving from the [report] the same conclusions and speculations about the pollution conditions on the property as those contained in” the internal documents that Technology Square did not turn over.

Considering whether withholding these documents was a material misrepresentation as a matter of law,²⁵⁷ the court held that “the conclusions that an environmental professional could have drawn from the Phase I Report were various” and that it could not be determined as a matter of law,

²⁵² *Id.*

²⁵³ Tech. Square, LLC, 2007 WL 534450, at *5.

²⁵⁴ *Id.* (“Kemper’s offer was ‘significantly more expensive’ than the one provided by UNIC, although both underwriters had received the same information”).

²⁵⁵ *Id.*

²⁵⁶ *Id.*, at *7-*8. The policy defined the exclusion as follows: “[k]nown conditions . . . arising from ‘Pollution Conditions’ existing prior to the inception of this Policy, and reported to any officer, director, partner or other employee responsible for environmental affairs of the Named Insured, unless all of the material facts relating to the ‘Pollution Conditions’ were disclosed to the company in materials prior to the inception of this Policy.” *Id.*, at *6.

²⁵⁷ The court applied the following standard: “A ‘material fact’ is one which would ‘naturally influence the judgment of [an] underwriter in making the contract at all, or in estimating the degree and character of the risk, or in fixing the rate of the premium.’” *Id.*, at *8.

even with deference to *Technology Square*, on a motion for summary judgment.²⁵⁸ The court further held that it could not decide whether the claim was for a “known condition” on summary judgment “while the facts that form the basis for providing coverage are in dispute.”²⁵⁹ The court determined that both the materiality of the information and whether the facts constituted information about “known conditions” were questions of fact for the jury.²⁶⁰

Thus, in both *Goldenberg* and *Technology Square* the court determined that the materiality of the information withheld and whether that information was related to a “known condition” were questions of fact.²⁶¹ In both cases, the courts might better have considered who should bear responsibility for identifying and carefully defining known conditions. The party bearing this responsibility would shoulder the burden of seeking out additional information pertaining to the site, requesting additional due diligence if the scope of the risk was particularly unclear, and sifting through relevant and irrelevant information to ensure accurate underwriting and unambiguous policy terms.

This approach would be in line with the policyholders’ arguments in *Goldenberg* and *Technology Square*. In those cases the policyholders argued that the insurers should bear the burden of seeking additional information about risk.²⁶² The implication of this argument is that a policyholder cannot misrepresent facts that it simply failed to recognize as important and that, if the insurer wants this information, it should ask for all the available data. The insurer should not be allowed to claim misrepresentation when, in retrospect, it wishes it had known certain facts but never asked for such information—even though it knew more reports and data were available.

Put more simply, the insurer should bear the burden of filtering through all the information in the name of efficiency. If all reports are requested and the insured does not turn over certain documents, the case for misrepresentation of known conditions would be relatively clear. If all the

²⁵⁸ *Technology Square*, 2007 WL 534450, at *10-*11.

²⁵⁹ *Id.* at *13.

²⁶⁰ *Id.* The court also granted summary judgment on a claim that the policy was supposed to cover property damage, which was expressly excluded under Coverage A of the contract. *Id.*, at *13-*14.

²⁶¹ *Id.*, at *12-*13; *Goldenberg I*, supra note 233, at *7-*9; see also *Chambliss Ltd.*, 2007 U.S. Dist. LEXIS 77664, at *15-*16.

²⁶² See *Goldenberg I*, supra note 233, at *3; see generally *Technology Square*, 2007 WL 534450.

reports are requested and turned over, and the insurer fails to identify pre-existing conditions from the reams of data, ignorance of the pre-existing condition becomes similarly clear. After all, the insurer is the repeat player with respect to performing risk assessment, and if it does not identify a risk when it has all relevant information, it would be hard to attribute superior knowledge to the insured. Moreover, the insurer has the incentive to broadly define the known condition, whereas the insured may choose to turn a skeptical eye on the relevance and implications of the facts before them. The result would be fewer cases going to trial, because the scope of known information would reside in the hands of an insurance underwriter, rather than the subjective hands of the policyholder.

A recent complaint by the Los Angeles Unified School District against AIG illustrates how this scenario might play out in practice. The school district was engaging in a school rehabilitation and construction project for which it purchased a PLL policy, which also contained Cost Cap provisions, from AIG after a bidding process. During negotiations, AIG agreed to assume responsibility for identifying all “known conditions” and to include policy endorsements expressly listing those conditions.²⁶³ The goal of this arrangement was to provide the school district with certainty that no dispute would later arise about whether a condition was known or unknown at the time the Policy was issued.²⁶⁴ According to the school district’s complaint, the policy included two endorsements containing exhaustive lists of known pollution conditions.²⁶⁵ AIG initially denied certain claims as known conditions, but entered into settlement negotiations with the school district after the initial complaint was filed.²⁶⁶

The case thus demonstrates the effectiveness of assigning the responsibility of identifying known conditions to the insurer.²⁶⁷ The approach clarifies what conditions should be deemed “known” under the policy, by producing the standard that anything the insurer failed to identify as a pre-existing condition is unknown for the purposes of the policy, assuming the policyholder turned over all requested information. Where the insurer has the upfront responsibility of delineating what is “known” by collecting all pertinent information, the insurer has added incentive to play an information-forcing role. It cannot, after a claim is produced, argue that the insured should have more clearly called attention to facts suggesting

²⁶³ *Id.* at 65.

²⁶⁴ *Id.*

²⁶⁵ *Id.*

²⁶⁶ *Id.* at 67.

²⁶⁷ See Waeger, *supra* note 72, at 65.

additional risk because the responsibility of doing so rested with its underwriters. Misrepresentation cases will thus be limited to those situations where the insured withheld explicitly requested information.

Applying *contra proferentem* to policies and adopting a narrow definition of “known conditions,” discussed earlier, would compliment burden-shifting the identification of known conditions to the insurer. With the responsibility of identifying known conditions and the knowledge that the conditions will be narrowly defined, insurers will assume responsibility for drafting clearer, specific terms. Furthermore, the insurer may feel compelled to set rigorous due diligence standards and disclosure requirements of all environmental reports. Having thorough information on the table will reduce the gray area between known and unknown conditions that are leading to litigation.

V. CONCLUSION: A TALE OF THREE BROWNFIELDS

As environmental insurance policies continue to play a key role in the redevelopment of brownfields, courts should be aware of the policies’ unique role relative to other liability coverage. Courts should interpret the terms of a policy in light of its relationship to its endorsements, while considering complimentary policies and regulatory influences. When construing its terms, particularly those pertaining to “known conditions,” the court should generally apply *contra proferentem* to encourage the insurer to play an information-forcing role while underwriting the policies. However, courts may wish to exercise their discretion and not apply *contra proferentem* where the policyholder is sophisticated and experienced with brownfield rehabilitation.

An illustration of three brownfield projects may elucidate how the recommendations of this Note might play out in practice. In each example, the court should first look to the policy language for guidance, analyzing the relationship between the endorsements and the standard form, perhaps considering complimentary policies for further guidance, and also taking into account relevant regulatory issues. Should ambiguities remain, the court must assess whether application of *contra proferentem* is justified.

At one extreme, Brownfield A is a “light” brownfield with little suspected contamination. The site’s developer does not usually deal with contaminated properties and purchases a PLL policy to cover possible liabilities, including clean up of “unknown” conditions. Remediation is not anticipated to be costly enough to justify the purchase of a Cost Cap policy to cover cost overruns in remediating “known” conditions. Since initial due diligence reveals little evidence of contamination other than some

trash, the insurer and developer agree on a policy with relatively few negotiated endorsements. Then, the developer discovers an oil barrel among the trash that has been leaking into the soil. The insurer refuses to cover the clean-up, arguing that the harm was caused by a “known condition,” namely the trash on the property. In this situation, a court would be justified in applying *contra proferentem* to the “known conditions” exclusion and holding that the spilled oil was not “known” for the purposes of the PLL policy. The bargaining power between the parties was relatively unequal and the policy had few individually negotiated components. And, unlike the insurer, the policyholder was not a repeat player and did not own a portfolio of sites. The insurer was thus in a better position to clarify the environmental risks and to ask questions about what due diligence might be necessary, assuming an information-forcing role.

On the opposite extreme, Brownfield B is a site with more substantial suspected contamination. The developer is a large multinational corporation that is currently remediating ten brownfields nation-wide and has successfully developed one hundred brownfields in the past twenty years. After substantial due diligence, the developer holds a series of meetings between its project managers, lawyers, and environmental consultants and representatives of its insurer. The parties discuss and thoroughly negotiate expanding the developer’s current PLL policy to cover Brownfield B and obtain a Cost Cap policy for the same purpose. The developer performs further due diligence at the prompting of the insurer, and the parties carefully identify the site’s “known conditions” before issuing coverage. Thereafter, a dispute arises over whether the developer misrepresented its knowledge of four storage tanks not marked on a map turned over to the insurer. A court in this case would be justified in refusing to apply *contra proferentem* because both parties were in a position of familiarity with environmental remediation and insurance policies. Less justification thus exists for placing the burden of information-forcing on the insurer.

Somewhere along the middle of the spectrum is Brownfield C which has substantial contamination and a sophisticated developer remediating it. The developer has redeveloped several brownfields in the past, but does not have a portfolio of properties. When a known condition dispute arises over insurance coverage for this site, the court will have a more difficult task than with Brownfield A and B in assessing whether *contra proferentem* is appropriate. Factors the court might consider would be the relative sophistication of the developer and the extent of the developer’s experience with brownfield rehabilitation. The court could also consider whether the insurer failed to perform adequate due diligence

in the underwriting or if the policyholder misrepresented information it should reasonably have known would be relevant to assessing the site's risks.

Generally speaking, courts may wish to give deference to the policyholder, and apply *contra proferentem* unless the policyholder is truly as sophisticated in assessing environmental risks as the insurer. Greater predictability regarding interpretation considerations and reduced litigation over potentially ambiguous terms will enhance environmental insurance's appeal as a tool for managing risk when redeveloping brownfields.

THE LIABILITY INSURANCE REGULATION OF RELIGIOUS INSTITUTIONS AFTER THE CATHOLIC CHURCH SEXUAL ABUSE SCANDAL

Alana Bartley¹

INTRODUCTION

Both religion and insurance play important roles in the lives of many around the world. And while one may never think of religion and insurance as being interrelated, they can both be seen as serving the same underlying purpose. As William Sumner has suggested, religion is an ancient form of insurance, since mankind “has tried in all ages somehow to insure himself – to take out a ‘policy’ of some sort on which he has paid regular premiums in some form of self-denial or sacrifice.”² This view presents an interesting comparison when considering the role of insurance in the sexual abuse scandal of the Roman Catholic Church.

The sexual abuse scandal within the Roman Catholic Church occurred in two distinct waves.³ The first instance in which knowledge of clergy sexual abuse became public was in the 1980s, when accounts of molestation by a widely-regarded priest in Louisiana surfaced in the media.⁴ Yet, like most news phenomena, the stories eventually faded from the news until another resurgence occurred in the 2000s.⁵ In 2002, many people throughout the United States began coming forward with allegations that they had been victims of sexual misconduct by Roman Catholic priests.⁶ There were so many allegations that it was impossible for Church officials to dispute the claims of sexual misconduct.⁷ Although similar

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² See Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471, 479-80 (1961) (quoting SUMNER & KELLER, *THE SCIENCE OF SOCIETY* 749 (1927)).

³ See *infra* text accompanying notes 25 to 68.

⁴ See *infra* text accompanying notes 25 to 37.

⁵ See *infra* text accompanying notes 38 to 68.

⁶ Nearly 200 people have come forward so far—all alleging that they were abused by the same priest, Father John J. Geoghan. See THE INVESTIGATIVE STAFF OF THE BOSTON GLOBE, *BETRAYAL: THE CRISIS IN THE CATHOLIC CHURCH* 6 (Little, Brown & Co. 2008). However, Geoghan was one of many priests who committed acts of sexual misconduct against parishioners. *Id.*

⁷ See *infra* text accompanying notes 56 to 61.

allegations had been previously made public, the sheer number of allegations arising at this time and the extensive media coverage of these stories of sexual misconduct made it seem like clergy sexual abuse was a relatively new problem for religious institutions;⁸ however, allegations of sexual misconduct by members of the Roman Catholic clergy were not a recent phenomenon,⁹ and allegations have plagued other religious groups as well.¹⁰ One study conducted estimated that approximately four percent of all Catholic priests serving between 1950 and 2002 have been accused of sexual misconduct.¹¹ The problem of sexual misconduct by priests within the Catholic Church was even confirmed by the repeated apologies of Pope John Paul II.¹²

As victims of clergy sexual abuse came forward, courts became overwhelmed with the unique legal issues the sexual abuse cases presented.¹³ When the first wave of accusations arose in the 1980s, diocese

⁸ See *infra* text accompanying notes 42 to 45.

⁹ Pamela Ferdinand, *Report Reveals Long History of Abuse by Boston Clergy*, WASH. POST, July 23, 2003, at A03 (“More than 1,000 people were likely sexually abused by more than 250 clergy and church workers in the Boston archdiocese over six decades.”); Jay Tokasz, *Pedophilia's Causes Complex: Counselors Say Need for Power, Misplaced Sexual Urges Play Roles*, DEMOCRAT & CHRON. (Rochester, N.Y.), Aug. 18, 2002, at 10A (featuring decades-old accusations of abuse against a Capuchin priest); *Draft Survey: 4,450 Priests Accused of Sex Abuse*, CNN, Feb. 17, 2004, <http://www.cnn.com/2004/US/02/16/church.abuse/index.html> [hereinafter *Draft Survey*] (detailing allegations of abuse from 1950 to 2002).

¹⁰ James T. O'Reilly & JoAnn M. Strasser, *Clergy Sexual Misconduct: Confronting the Difficult Constitutional and Institutional Liability Issues*, 7 ST. THOMAS L. REV. 31, 34 (1994) (“The Presbyterian Church U.S.A. estimates that 10 to 23 percent of clergy nationwide have engaged in inappropriate sexual behavior or sexual contact . . . The United Methodist Church reported in a 1990 survey that nearly 23 percent of the laywomen had been sexually harassed, 17 percent by their own pastor and 9 percent by another minister.”).

¹¹ *Draft Survey*, *supra* note 9.

¹² See, e.g., *Pope's Web Apology over Sex Abuse*, CNN, Nov. 23, 2001, <http://www.cnn.com/2001/WORLD/europe/11/22/pope.apology/>; Alessio Vinci, *Pope Responds to Sex Abuse Cases*, CNN, Mar. 22, 2002, <http://www.cnn.com/2002/WORLD/europe/03/21/vatican.sex.abuse/>.

¹³ Jesse J. Cooke, *Beyond an Unfortunate "Occurrence": Insurance Coverage and the Equitable Redress of Victims of Sexual Predator Priests*, 36 ARIZ. ST. L. J. 1039, 1041 n.10 (2004) (noting the various issues as including: “[H]ow far, if at all, will the courts, as instruments of the government, interfere with the Catholic Diocese, a religious entity protected by First Amendment concepts of separation of

possessed general liability insurance to cover injuries occurring on church property.¹⁴ One of the main issues within the cases arising during this time was whether the general liability insurance for the Churches covered the lawsuits and injuries arising out of the priest's sexual misconduct.¹⁵ Often, this question rested on the Court's interpretation of the definition of "occurrence,"¹⁶ which is commonly defined as "an 'accident' that 'results in bodily injury or property damage *neither expected nor intended* from the standpoint of the insured.'¹⁷ Courts found that the question of whether there is coverage turns on the Court's interpretation of what is an "*accident . . . neither expected nor intended*."¹⁸ Courts have reached varying outcomes on this issue.¹⁹ As a result, liability insurance companies began

church and state; how would courts be willing to extend applicable statute of limitations in instances where victims' memories of abuse were recovered only after years of repression; how should criminal penalties and civil sanctions be adjusted to address the particularly heinous nature of these acts; how would further governmental oversight of internal church activities be implemented to interrupt the common church practice of nonreporting the allegations filed by parishioners; how would courts mandate that the Catholic diocese's insurance carriers indemnify any awards to abuse victims as the perpetrator's employer; how would courts determine liability for conduct that was often repeated, involved numerous victims, and extended over long periods of time.").

¹⁴ See TIMOTHY D. LYTTON, HOLDING BISHOPS ACCOUNTABLE: HOW LAWSUITS HELPED THE CATHOLIC CHURCH CONFRONT CLERGY SEXUAL ABUSE 76 (Harvard Univ. Press 2008).

¹⁵ See *infra* text accompanying notes 77 to 85.

¹⁶ Liability insurance policies can either afford coverage for claims or occurrences. A claims-based insurance policy covers all claims made in the year of the policy. See *Graman v. Cont'l Cas. Co.*, 409 N.E.2d 387, 390 (Ill. App. Ct. 1980) ("It is well-established that the 'claims made' or 'discovery' policy is characterized by coverage for negligent acts or omissions only if such are discovered during and brought to the attention of the insurer within the policy term."). Compare *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56, 59 (3d Cir. 1982) ("Occurrence policies indemnify the insured for acts or occurrences which take place within the policy period."). Whether coverage is based on an occurrence policy or a claims-based policy depends on the language of the policy and the court's interpretation of the policy. James A. Serritella, *Insurance Coverage Issues in Cases of Clergy Misconduct*, 39 CATH. LAW. 55, 57 (1999). This article deals solely with occurrence policies.

¹⁷ ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW 518-19 (1988) (1988).

¹⁸ *Id.*

¹⁹ *McAuliffe v. N. Ins. Co. of N.Y.*, 69 F.3d 277, 279 (8th Cir. 1995) (holding that a liability insurance policy held by the Catholic Diocese of Jefferson City,

including clauses specifically exempting injuries and lawsuits arising out of sexual misconduct in policies sold to religious institutions.²⁰ The exemption of sexual misconduct from general liability insurance policies has caused religious institutions to specifically purchase insurance against clergy sexual misconduct, in addition to their general liability insurance policy.²¹ However, even when the sexual misconduct policies have been purchased, not all claims are accepted under the policy, and the vast majority of claims are denied.²² This article will show that through these actions, liability insurance companies have shifted the risk back to the religious institutions and have, in a sense, “regulated” religious institutions, causing them to be more proactive in taking precautions to prevent their clergy from committing acts of sexual misconduct with parishioners.

Part I of this Note describes the history of the Catholic Church sexual abuse scandal, delineated into two periods of litigations, each induced by a significant case. Statistics of the amount of clergy sexual abuse claims are also discussed. Part II addresses liability insurance generally, and then details how liability insurance has affected the Catholic Church sexual abuse scandal. Part III discusses the litigation of clergy sexual abuse cases, including how the term “occurrence” in liability insurance policies has been interpreted by the courts. Part III also describes how “bodily injury” has been interpreted by courts in clergy sexual abuse cases. Part IV addresses the aftermath of litigation, including how courts have dealt with self-insured retentions when damages are awarded. Part IV also discusses how liability insurance policies for religious institutions have changed in the aftermath of the Catholic sexual abuse scandal.

I. THE CATHOLIC CHURCH SEXUAL ABUSE SCANDAL

A. HISTORY

Reports of sexual abuse by priests within the Catholic Church can be found dating back to the nineteenth century.²³ However, these instances attracted little to no press coverage and were largely unknown because the

Missouri excluded coverage of claims arising out of a priest’s sexual relationship with a parishioner). *Compare infra* text accompanying notes 133 to 156.

²⁰ LYTTON, *supra* note 14, at 76-77.

²¹ *See id.* at 76.

²² *Id.* at 77.

²³ *Id.* at 43.

resulting civil claims were quietly settled.²⁴ In 1984, a civil lawsuit alleging clergy sexual abuse filed against Father Gilbert Gauthé and the Diocese of Lafayette attracted national attention to clergy sexual abuse. As a result, many other victims of clergy sexual abuse came forward and also filed claims. Yet, as what occurs with many news phenomena, the stories of clergy sexual abuse faded from the public's consciousness until 2002, when another shocking case of clergy sexual molestation claimed the media's attention. As with the Gauthé case, the Geoghan case also led to a surge of victims to come forward and make claims against the Church.

1. 1984-1991

Father Gauthé was a highly regarded priest in Henry, Louisiana.²⁵ However, during his five and a half year tenure, he sexually molested young boys in his parish.²⁶ Gauthé was first accused when a 9-year-old child told his parents of the abuse, stating that the incident made him think that "God doesn't love [him]."²⁷ When the boy's parents discussed the matter with other parents in the community, it was discovered that Gauthé's exploitation did not end with one boy.²⁸ The parents of the violated children went to a local attorney, who voiced a complaint to the bishops of the diocese.²⁹ In response, the bishops removed Gauthé from the diocese, but they refused to publicly announce why he was removed or what he had done.³⁰ Frustrated by the Church's response to their complaint, the families filed suit.³¹

At the time of the Gauthé case, other cases alleging clergy sexual abuse had been previously filed in California, Oregon, Idaho, Wisconsin, Minnesota, New York, Pennsylvania, New Jersey, and Rhode Island.³² Yet the Gauthé case gave clergy sexual abuse national attention as it was covered in *Time* magazine, the *New York Times*, and the *Washington Post*.³³ However, only the American public was first learning of the clergy sexual abuse epidemic; the Catholic Church had known about the problem

²⁴ *Id.*

²⁵ *Id.* at 1.

²⁶ LYTTON, *supra* note 14, at 1.

²⁷ *Id.* at 1.

²⁸ *Id.* at 1-2.

²⁹ *Id.* at 2.

³⁰ *Id.*

³¹ *Id.*

³² LYTTON, *supra* note 14, at 2.

³³ *Id.* at 14.

of clergy sexual abuse for years.³⁴ In response to the media attention on the case, states increased reporting requirements and relaxed their statute of limitations for child sexual abuse.³⁵ In addition, youth programs implemented required fingerprinting, background checks, and references of people working with children.³⁶

The Gauthé case paved the way for the national attention on clergy sexual abuse cases. After the case hit the mainstream media, victims of clergy sexual abuse began coming forward with their stories and a number of cases alleging clergy sexual abuse were filed.³⁷ However, similar to the previous era where the allegations did not make national headlines, most of these cases quietly settled.³⁸ As a result, clergy sexual abuse faded from the nation's conscience. In 2002, clergy sexual abuse was once again thrust onto the front pages of the newspapers with the emergence of sexual abuse claims against Father Geoghan and the Boston Archdiocese.

2. 2002- Present

Stories of the most current wave of clergy sexual abuse within the Catholic Church first began appearing in the *Boston Globe* in the winter of

³⁴ “[P]ersonnel files in dioceses around the country document complaints dating back to the 1930s.” *Id.*

In 1976 the Servants of the Paraclete [a Catholic religious order] opened what was perhaps the first program in the world with a treatment regime designed to treat psychosexual disorders including disorders involving the sexual abuse of minors. The ability of the Catholic community to design and implement such a program is both a reflection of the need for such a program and the degree of knowledge of the scope of the problem of sexual misconduct with children by Catholic priests and religious. The fact that preparations for the opening of the program were years in the making demonstrates widespread knowledge of existing sexual misconduct with minors by Catholic clergy by the late 1960s and early 1970s.

A.W. Richard Sipe, *Sipe Report* (BishopAccountability.org, Waltham, MA), at ¶ 48, available at www.bishopaccountability.org/tx-dallas/resource-files/snipe-report.htm.

³⁵ LYTTON, *supra* note 14, at 15.

³⁶ *Id.*

³⁷ According to a study commissioned by the U.S. Conference of Catholic Bishops, 328 abuse reports were made in the five years prior to the Gauthé case, while 817 were received in the five years following. *Id.*

³⁸ See INVESTIGATIVE STAFF, *supra* note 6, at 3-4.

2002.³⁹ What differentiated these stories from the previous wave was that the stories not only featured the acts of sexual abuse committed by individual priests, but they also detailed the lengths other high-ranking priests, including Cardinal Bernard F. Law, the most influential American Catholic priest, had gone to cover up the incidents of sexual abuse.⁴⁰ The public was shocked by the accusations, as the acts of sexual misconduct violated childrens' innocence, parents' trust, priestly vows, bishops' responsibilities, and the basic tenants of the Catholic Church.⁴¹ However, the evidence supporting the claims of the acts of sexual abuse, and the massive cover-up of these claims, was irrefutable.⁴²

Before the news of the Geoghan sexual abuse cases broke, lawyers for the Church would quietly settle cases with sexual abuse victims.⁴³ However, after the news broke, these same lawyers publicly declared the private settlement agreements not to be in the Church's or the public's best interest, as the extent of the sexual abuse remained concealed.⁴⁴ Additionally, law enforcement officers in Boston, who had previously turned a blind eye to accusations of sexual misconduct due to fear of exposing the Church they belonged to, began to seek records so they could decide whether to prosecute priests who had committed sexual abuse.⁴⁵ Within these records, there was overwhelming evidence that the

³⁹ *Id.* at 3.

[Boston] became the epicenter of the scandal, because the story broke there, because of the sheer number of priests implicated there, and because of the Catholic character of the city. More than 2 million of the 3.8 million people who live in the metropolitan Boston area are Catholic. It is the only major archdiocese in the United States where Catholics account for more than half of the population. In no other major American city are Catholics more represented in police precincts, courtrooms, or boardrooms.

Id. at 7.

⁴⁰ *Id.* at 3. Cardinal Law and the members of the Boston Archdiocese were not the only Church officials to cover up accusations of clergy sexual abuse. The practice of removing accused priests to other dioceses was widespread. Cardinal Law's involvement was shocking to the public, however, because he was a widely known and influential figurehead of the Catholic Church. *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ See INVESTIGATIVE STAFF, *supra* note 6, at 3-4.

⁴⁴ *Id.* at 4.

⁴⁵ *Id.*

Archdiocese of Boston chose to protect the reputation of the Church at the expense of the sexual abuse victims.⁴⁶

Boston was not the only Archdiocese implicated by the Catholic Church sexual abuse scandal.⁴⁷ Across the country, many priests were pulled from their assignments;⁴⁸ Bishops across the United States and Europe resigned.⁴⁹ The Pope addressed the scandal in his Holy Thursday letter to priests, but his statements in this letter were meant to “comfort good priests,” and did not mention the victims at all.⁵⁰

Others within the Church were more sympathetic to the sexual abuse victims. In his Good Friday letter, Cardinal Law stated,

Betrayal hangs like a heavy cloud over the Church today...While we do not presume to judge anyone's relationship with God, there is no doubt that a betrayal of trust is at the heart of the evil in the sexual abuse of children by clergy. Priests should be trustworthy beyond any shadow of a doubt. When some have broken that trust, all of us suffer the consequences.⁵¹

Even with his sympathetic public statements, opinion polls found a sense of disillusionment among parishioners with the Cardinal's handling of the sexual abuse scandal; many called for Cardinal Law to resign.⁵² Many Catholics responded to the church's handling of the scandal by withholding money from the archdiocese.⁵³

Three months after the news of the scandal broke, the Pope summoned all of the American cardinals to the Vatican for an emergency meeting.⁵⁴ At this meeting, the Pope's tone changed drastically from his Holy Thursday letter. He stated that the sexual abuse of minors by priests was not only an “appalling sin” but was also a crime.⁵⁵ Also unlike his previous letter, the Pope addressed the victims of the clergy sexual abuse,

⁴⁶ *Id.*

⁴⁷ *See id.*

⁴⁸ In the United States, 176 priests were pulled in the first four months of 2002. *Id.*

⁴⁹ *Id.*

⁵⁰ INVESTIGATIVE STAFF, *supra* note 6, at 4

⁵¹ *Id.*

⁵² *Id.* at 5.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ INVESTIGATIVE STAFF, *supra* note 6, at 5.

stating “[t]o the victims and their families, wherever they may be, I express my profound sense of solidarity and concern.”⁵⁶

In contrast to the past, the Church could not deny the existence of a sexual abuse problem when the documents from the Boston Archdiocese clearly demonstrated Cardinal Law and his aides were repeatedly warned about certain priests, but took no action to keep them from sexually abusing children.⁵⁷ The alarming case of Father Geoghan was the most prominently featured in exposing the cover-up.⁵⁸

Geoghan was a serial molester.⁵⁹ Almost two hundred claims of sexual abuse were filed against him and his supervisors, and some believe that the number of his actual victims could be three to four times as many as have made claims.⁶⁰ Geoghan’s astounding number of victims is due to the fact that when a complaint was filed against him in a particular parish, he would be moved to a new parish and his new parishioners would not be made aware of the previous allegations of sexual abuse made against him.⁶¹ Although Geoghan’s case is the most notorious, and perhaps the most egregious, moving accused priests from one parish to another was a common practice throughout the Catholic Church when allegations of sexual misconduct arose.⁶²

Geoghan’s victims came forward and filed suits against him and the Church. The Church’s lawyer successfully moved to have the case files sealed, as was common in clergy sexual abuse cases.⁶³ However, the *Boston Globe*, who was looking to do a series on clergy abuse, sued to have the case files unsealed.⁶⁴ The Judge ruled in favor of the *Globe*, and the resulting series was the spark that re-ignited national attention on the clergy sexual abuse cases.⁶⁵ These documents provided much of the proof that the Church knew of the abuse complaints against Geoghan, yet continued to

⁵⁶ *Id.*

⁵⁷ *Id.* at 5-6.

⁵⁸ *See id.* at 6.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ INVESTIGATIVE STAFF, *supra* note 6.

⁶² *See id.* In one case, Cardinal Law wrote another diocese and gave a priest, who he knew had been accused of sexual abuse, a good retirement letter and stated that the priest should head a Church-run guest home, whose guests included youths. *Id.*

⁶³ LYTTON, *supra* note 14, at 33. It is for this reason that there have only been periods of media coverage of clergy sexual abuse cases.

⁶⁴ *Id.*

⁶⁵ *Id.*

move him from parish to parish.⁶⁶ As with the Gauthé case, the national attention of the Geoghan case induced a resurgence of suits by victims of clergy sexual abuse.

B. STATISTICS

The fact that the Gauthé and Geoghan cases caused increases in clergy sexual abuse claims can be illustrated by insurance company data during this time period. Between 1989 and 2005, "Company A" provided sexual misconduct coverage to U.S. Catholic dioceses.⁶⁷ Between 1990 to the present, "Company A's" market share of clergy sexual misconduct coverage was "30 percent in 1990, 40 percent in 1995, 45 percent in 2000, and 50 percent in 2005."⁶⁸ Of a total of 275 clergy sexual abuse misconduct claims made against policies, over one-third of the claims were made in the times after the Gauthé case and during the Geoghan case.⁶⁹ Therefore, the data shows that the media attention of these two sexual abuse cases caused a dramatic increase in clergy sexual abuse claims.

However, the fact that a claim of clergy sexual abuse has been made by a victim does not guarantee the victim will see restitution.⁷⁰ The surge of claims filed after the Gauthé case opened the door for a bounty of insurance issues that needed to be resolved before it was decided if victims would receive damages.

II. HOW LIABILITY INSURANCE HAS AFFECTED THE CATHOLIC CHURCH SEXUAL ABUSE SCANDAL

A. LIABILITY INSURANCE IN GENERAL

A basic tenant of liability insurance is that it compensates for accidental injuries or unexpected loss; intentional acts are not covered.⁷¹

⁶⁶ *Id.*

⁶⁷ *Id.* at 53.

⁶⁸ *Id.*

⁶⁹ See LYTTON, *supra* note 14, at 53.

⁷⁰ *McAuliffe*, 69 F.3d at 280 (holding that a liability insurance policy held by the Catholic Diocese of Jefferson City, Missouri excluded coverage of claims arising out of a priest's sexual relationship with a parishioner).

⁷¹ *Serritella*, *supra* note 16, at 55; *Allstate Ins. Co. v. Mauldin*, 869 F. Supp. 478, 479 (W.D. Tex. 1994) (noting "courts afford coverage for fortuitous damages but deny coverage when damages are the natural and probable consequences of intentional conduct.").

“If a single insured is allowed to consciously control the risks covered by the policy, a central concept of insurance is violated.”⁷² For example, most owners of commercial property obtain a commercial general liability insurance policy to protect themselves against the risk of liability for accidents and injuries occurring on their property.⁷³ Religious institutions are no different.

When a policy is obtained, the insuring agreement obligates the insurer to pay any legal obligations of the insured due to bodily injury or property damage caused by an occurrence during the policy period.⁷⁴ The coverage for these policies typically provides for bodily injury or property damage to a third party, medical expenses accruing to the underlying incident, and the costs of defending lawsuits.⁷⁵ The cost of a lawsuit includes investigations and settlements, and any bonds or judgments required during an appeal process.⁷⁶

Whether coverage will be extended under the policy is determined by whether the claimed event can be considered an “occurrence.”⁷⁷ In commercial general liability insurance policies, an “occurrence” is typically defined as “[a]n accident, including continuous or repeated exposure to conditions, which results during the policy period in bodily injury or property damage neither expected nor intended from the standpoint of the insured.”⁷⁸ When claims are made against them, the insured turns to the general liability carrier for defense and indemnification in the event damages are awarded.

In the context of the Catholic Sexual Abuse scandal, “[d]efinitions, exclusions, and occurrence provisions make up the significant policy language where damages are sought against the Diocese.”⁷⁹ These terms have been extremely relevant when parishioners allege priests have committed unthinkable crimes against them.⁸⁰ As most parishes only carried general liability insurance when the initial wave of claims of clergy

⁷² *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386, 1392 n.7 (8th Cir. 1996).

⁷³ Commercial general liability insurance policies can also insure businesses from exposure to liability related to their products.

⁷⁴ KENNETH S. ABRAHAM, *INSURANCE LAW AND REGULATION: CASES AND MATERIALS* 408 (3d. 2000).

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ Cooke, *supra* note 13, at 1043.

⁸⁰ *Id.* at 1044.

sexual abuse arose,⁸¹ courts were forced to use definitions, exclusions, and insurance provisions to decide whether and how church insurance policy language applies in cases where victims of clergy sexual abuse were awarded civil damages.

The analysis of what constitutes an occurrence in resolving whether there is liability insurance coverage has many crucial determinations. Concluding what events are considered to be occurrences, the time an occurrence is found to have taken place, and the number of occurrences that took place is critical, especially when coverage is disputed.⁸² Insurance coverage for an incident often depends on the event falling within the policy's definition of an occurrence.⁸³ Also, when a policyholder has taken a succession of policies over time, the date of the occurrence determines which policy the claim falls under.⁸⁴ The determination of which policy covers the claim is important because all liability insurance policies are sold with specific limits on the amount of money that the insurer is obligated to pay for a particular claim or event.⁸⁵ The insurer's payment will not exceed this amount even if damages owed by the insured are greater.⁸⁶ Therefore, the amount of insurance coverage available to the insured is affected by the number of occurrences found to have taken place during a specific period of time.

⁸¹ See LYTTON, *supra* note 14, at 76. "... Michael Bemis, president and CEO of The National Catholic Risk Retention Group, one of the primary liability insurance providers to the Catholic Church" stated:

[T]he Gauthier claims, we've all since learned, were just the tip of the iceberg. But they were spectacular at the time and [reinsurance] underwriters at Lloyd's . . . took 100 percent loss ratios [i.e., zero profit on the coverage sold], simply based on sexual misconduct claims that they never expected to pay because they didn't think there were going to be sexual misconduct claims . . . So they really took a beating.

⁸² Cooke, *supra* note 13, at 1043.

⁸³ See ABRAHAM, *supra* note 74, at 408.

⁸⁴ Cooke, *supra* note 13, at 1043.

⁸⁵ Tom Baker, *Liability Insurance as Tort Regulation: Six Ways That Liability Insurance Shapes Tort Law in Action*, 12 CONN. INS. L. J. 1, 6 (2005). In addition to per-claim or per-event limits, an insurance policy may also have a specified limit on the amount of money the insurer is obligated to pay for all claims covered by the policy as a whole. *Id.*

⁸⁶ *Id.*

B. LIABILITY INSURANCE AND THE CATHOLIC CHURCH SEXUAL ABUSE SCANDAL

As insurance has become increasingly more entwined with tort law, it has been noted that “[i]nsurance has a fundamental effect on . . . the defendant’s ability to pay and the facility with which the defendant can be made to pay.”⁸⁷ Because of consumer debt, the ability of bankruptcy to discharge civil liabilities, and the existence of exemptions to the assets that must be liquidated in a bankruptcy proceeding, “liability insurance is the only asset that plaintiffs can count on collecting.”⁸⁸ Guaranteed collection is a very important notion in the context of the sexual abuse claims against the church as priests have little to no assets. As a result, for a claimant to be successful in obtaining damages, and a lawyer working on a contingency basis to want to handle their case, there has to be a party who has the ability to pay the damage award. For this reason, the diocese and their respective insurers are always named as defendants in claims alleging clergy sexual abuse.⁸⁹ They have much larger bank accounts than the priests who commit the offenses.⁹⁰

The problem with the insurance coverage for sexual abuse acts is that sexual abuse, by definition, is never an accidental act.⁹¹ Yet, as previously discussed,⁹² liability insurance policies have an exclusion for intention harm,⁹³ and only apply to “occurrence[s]...neither expected nor

⁸⁷ *Id.* at 4.

⁸⁸ *Id.*

⁸⁹ *See id.*

⁹⁰ Derrick Z. Jackson, *Archdiocese Adds Up as Big Business*, BOSTON GLOBE, Feb. 13, 2002, available at http://www.boston.com/globe/spotlight/abuse/stories/021302_jackson.htm (“Nationally, the Catholic Church takes in \$8.2 billion a year in donations at the parish level . . . plac[ing] the church ahead of R.J. Reynolds Tobacco, Pepsi bottling, John Hancock Financial Services, General Mills, Kellogg, America Online, Union Carbide, Campbell’s Soup, and Quaker Oats [in terms of revenues.]”).

⁹¹ *See, e.g.*, 18 U.S.C.A. § 2242 (West 2000) (“Whoever . . . knowingly . . . engages in a sexual act with another person if that other person is . . . incapable of appraising the nature of the conduct; or physically incapable of declining participation in, or communicating unwillingness to engage in, that sexual act; or attempts to do so, shall be fined under this title and imprisoned for any term of years or for life.”).

⁹² *See supra* text accompanying notes 76 to 82.

⁹³ Baker, *supra* note 85, at 8 (“[T]he exclusion for intentional harm . . . is nearly universal in liability insurance policies in the U.S. covering bodily injury.”).

intended.”⁹⁴ Because of this exclusion, plaintiffs looking to recover large damage awards must allege a form of negligence on the part of the Church in order for their incident to be covered under the Church’s insurance policy. In cases alleging clergy sexual abuse, this has been done under the theories of respondeat superior, negligent infliction of emotional distress, clergy malpractice, and negligent/reckless hiring and supervision.⁹⁵ Claims made under the theory of negligent supervision have had the most success.⁹⁶

Within the theory of negligence, liability attaches to a person if the person fails to employ reasonable care and subsequently injures another person.⁹⁷ However, liability only exists under these circumstances when (1) the injury that occurred could have been reasonably foreseen and care could have been taken to prevent it and (2) where the risk of the injury did not arise due to third party conduct, unless a special relationship exists between either the liable person and the third party injurer or the liable person and the victim.⁹⁸

When defending against a claim of negligent supervision, the diocese needs to show that it did not expect nor intend for injuries to occur to be covered by liability insurance.⁹⁹ Any evidence that would establish a reasonable foreseeability on the part of the diocese would make it impossible for an event to be considered an occurrence.¹⁰⁰ During the Catholic Church sexual abuse scandal, it was discovered that many churches kept extensive documentation of internal Church communications

⁹⁴ ABRAHAM, *supra* note 74, at 408.

⁹⁵ Cooke, *supra* note 13, at 1051.

⁹⁶ Soc’y of the Roman Catholic Church of the Diocese of Lafayette & Lake Charles, Inc. v. Interstate Fire & Cas. Co., 26 F.3d 1359 (5th Cir. 1994) (denying parent’s claims, but awarding negligent supervision claims); Rita M. v. Roman Catholic Archbishop of Los Angeles, 232 Cal. Rptr. 685, 690 (Cal. Ct. App. 1986) (setting aside respondeat superior claims because the abuse was not a required duty of the priest and abuse was not a reasonably foreseeable consequence of the priest’s duties); O’Reilly & Strasser, *supra* note 10, at 39 (“State courts have tended to decline the invitation to apply respondeat superior to clergy sexual misconduct.”).

⁹⁷ LYTTON, *supra* note 14, at 58.

⁹⁸ *Id.*

⁹⁹ *See id.*

¹⁰⁰ *See id.*

revealing the Church's awareness of priests who had numerous abuse allegations made against them, and their resulting relocations.¹⁰¹

The Church practice of relocating priests who had sexual misconduct allegations lodged against them was longstanding.¹⁰² This practice continued until the media discovered the extensive sexual abuse allegations and more careful scrutiny was placed on the Church.¹⁰³ The documentation proving that the Catholic Church authorities were aware of many abusive priests and did little to prevent the abuse from continuing made them susceptible to claims of negligence within lawsuits.¹⁰⁴

Although the Church did know about the sexual abuse allegations, law enforcement officials did not.¹⁰⁵ Victims who came forward usually filed formal complaints against the priest with the Church, so many of the matters were handled informally and kept away from the public knowledge.¹⁰⁶ The practice of relocating accused priests, in part, stems from the fact that most laws which compel the disclosure of sexual abuse

¹⁰¹ Cooke, *supra* note 13, at 1051-52. The Catholic Church, when an allegation of sexual abuse was received, would, either verbally or in writing, reprimand the priest, mandate therapy, and then relocate them to a different area where the allegations would be unknown to the parishioners. *Id.*

¹⁰² See *supra* text accompanying notes 57 to 62.

¹⁰³ See, e.g., INVESTIGATIVE STAFF, *supra* note 6, at 53 (stating that Father John Geoghan committed known sexual abuse for thirty years in six different parishes).

¹⁰⁴ A February 9, 1996 letter from the Archbishop of Boston to Father Graham, a priest accused of sexual abuse, shows the Church was aware of the allegations and did nothing to prevent them. The letter reads, in part:

The Review Board and the Delegate have recommended that your case be determined to be a case reported and handled appropriately before the present Policy was in place, and thus one to which the Policy does not apply. They recommended that you do not require further assessment and there should be no limits or restrictions on your ministry. I hereby approve the recommendation.

Letter from Cardinal Bernard Law, Archbishop of Boston, to Reverend Daniel M. Graham, Saint Joseph Rectory (Feb. 9, 1996), *available at* http://www.boston.com/globe/spotlight/abuse/documents/law_letter_020996.htm.

¹⁰⁵ See *supra* text accompanying notes 43 to 46.

¹⁰⁶ See, e.g., INVESTIGATIVE STAFF, *supra* note 6, at 53 (stating that Father John Geoghan committed known sexual abuse for thirty years in six different parishes).

accusations apply specifically to professional organizations.¹⁰⁷ These laws do not expressly require Church officials to report these accusations.¹⁰⁸ In the states that require disclosure from religious institutions, the churches claimed they were not aware of mandatory-reporting laws, argued that these types of matters were best handled within the Church, or contended that reporting these types of matters to law enforcement would have been contrary to the Church's "culture of forgiveness."¹⁰⁹

III. LITIGATING CLERGY SEXUAL ABUSE CASES

A. HOW "OCCURRENCE" HAS BEEN INTERPRETED BY THE COURTS

On its own, the Catholic Church has taken a very passive stance in redressing the harms to the clergy sexual abuse victims. Many times, the Church would make an accused priest go to therapy for their molestation of children.¹¹⁰ The Roman Catholic Church has internal rules that inhibit a priest's discharge for sexual misconduct,¹¹¹ although the Church forbids sexual misconduct.¹¹² Perhaps for this reason, courts have tried to work

¹⁰⁷ Mark Clayton, *Why Child Abuse Goes Unreported*, CHRISTIAN SCIENCE MONITOR, Mar. 18, 2002, <http://www.csmonitor.com/2002/0318/p01s05-usju.html> (noting that "[eighteen] states have mandatory-reporting laws that do not specifically require clergy to report sexual abuse of children . . . [nineteen] mandate that church officials . . . pass on information . . . [and in six states] the clergy's status is unclear. Seven states always require churches to relay information, even what's heard in the confessional . . .").

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ Kate S. Lombardi, *Parish Recalls Priest in a Sex Case*, N.Y. TIMES, July 25, 1993, available at <http://www.nytimes.com/1993/07/25/nyregion/parish-recalls-priest-in-a-sex-case.html>.

¹¹¹ For instance, the Code of Canon Law mandates the intervention of the Vatican before releasing a priest from his duties for sexual misconduct where psychological or physical deficiencies are present. See 1983 CODE c.1324, § 1, available at http://www.vatican.va/archive/ENG1104/_P4W.HTM (stating that punishments for violations "be tempered" if the violation was committed "by a person who had only the imperfect use of reason . . . because of drunkenness or . . . similar culpable disturbance of mind."). See also *id.* at c.1342-53, available at http://www.vatican.va/archive/ENG1104/_P50.HTM (limiting the unilateral actions of those administering penalties).

¹¹² *Id.* at c.1395, § 2, available at http://www.vatican.va/archive/ENG1104/_P56.HTM.

with the policy language to find coverage so victims can receive some form of remedy.

Courts seeking to redress victims of clergy sexual abuse have had a difficult time with the accidental nature of occurrence defined in the policy language. “Clever judicial constructions of occurrence have resulted in unpredictable, often excessive, coverage awards to churches found to be liable to abuse victims.”¹¹³ Single-injury cases have proved to be the exception, however, as they have almost unanimously been found to involve only one occurrence.¹¹⁴ Cases where the abuse has occurred over a long period of time, where many victims are involved, where multiple insurance providers have been used by the diocese, and where varying layers of coverage exist require a more intricate analysis.

1. The Fifth Circuit

*Society of the Roman Catholic Church v. Interstate Fire & Casualty Co.*¹¹⁵ presented the question of how many occurrences took place in a sexual abuse situation involving two priests who abused over thirty children over a six-year time span.¹¹⁶ Although the exact number of instances of molestation was not disclosed in the case, it was agreed to by the parties that each child had been abused at least one time per year over the six year period.¹¹⁷ During this time frame, the diocese had numerous primary and excess insurance policies.¹¹⁸

The District Court held that each abused child constituted an occurrence and that the first encounter rule should be used in delegating coverage among insurers.¹¹⁹ In reaching this conclusion, the Court applied the effects test, which treated each individual victim as an individual occurrence.¹²⁰ The rationale of the effects test is that the number of occurrences should be determined from the standpoint of the insured, not

¹¹³ Cooke, *supra* note 13, at 1054.

¹¹⁴ ABRAHAM, *supra* note 74, at 442.

¹¹⁵ 26 F.3d 1359.

¹¹⁶ *Id.* at 1361.

¹¹⁷ *Id.* at 1361-62.

¹¹⁸ *Id.* at 1362.

¹¹⁹ *Id.* at 1362-63. The first encounter rule is defined by the court as saying that “the insurance carrier covering the Diocese during the occurrence of the first molestation of each child was responsible for all resulting damages to that child... including damages from molestations occurring after the expiration of that carrier’s policy.” *Id.* at 1363.

¹²⁰ 26 F.3d at 1363-64.

its victims,¹²¹ as it does not take into account the number of times the victims may have been abused.

However, the Court of Appeals rejected the lower court's holding and stated that "the church's continuous negligent supervision of a priest, the negligent supervision of a priest with respect to each child, the negligent supervision of a priest with respect to each molestation, or each time the diocese became aware of a fact which should have led it to intervene," were all events that could be an occurrence depending on the court's approach.¹²² The Court of Appeals took the occurrence analysis from asbestos cases,¹²³ and held that:

When a priest molested a child during a policy year, there was both bodily injury and an occurrence triggering policy coverage. All further molestations of that child during the policy period arose out of the same occurrence. When a priest molested the same child during the succeeding policy year, again there was both bodily injury and an occurrence. Thus, each child suffered an "occurrence" in each policy period in which he was molested.¹²⁴ Any instances of CSA that followed the coverage-triggering act and occurred in the same coverage year, were not deemed occurrences, but conditions from which "repeated exposure . . . unexpectedly result[ed] in personal injury."¹²⁵

Here, the court, in holding that the first encounter rule should not apply because "a subsequent molestation, occurring outside the policy period, is not a consequential damage of the previous molestation; it is a new injury, with its own resulting damages,"¹²⁶ strikes a balance between finding an occurrence for every instance of molestation and denying that an

¹²¹ *Id.* at 1362.

¹²² *Id.* at 1364.

¹²³ *Porter v. Am. Optical Corp.*, 641 F.2d 1128 (5th Cir. 1981); *Ducre v. Mine Safety Appliances Co.*, 645 F. Supp. 708 (E.D. La. 1986); *Cole v. Celotex Corp.*, 599 So. 2d 1058 (La. 1992); *Houston v. Avondale Shipyards, Inc.*, 506 So. 2d 149 (La. Ct. App. 1987). These cases applied the exposure rule to conclude that inhalation of asbestos constituted a single occurrence each year that asbestos was ingested. *Soc'y of the Roman Catholic Church*, 26 F.3d at 1365.

¹²⁴ *Soc'y of the Roman Catholic Church*, 26 F.3d at 1364.

¹²⁵ *Id.* at 1366.

¹²⁶ *Id.*

occurrence has taken place altogether.¹²⁷ In this sense, the analysis “would lessen coverage to a church whose negligent supervision allowed a child to be abused one hundred times in one policy year (thus constituting one occurrence), than to a church that allowed two instances of [clergy sexual abuse] over two policy years (thus two occurrences).”¹²⁸

2. The Ninth Circuit

In *Interstate Fire & Cas. Co. v. Archdiocese of Portland in Oregon*, 35 F.3d 1325 (9th Cir. 1994),¹²⁹ the Court of Appeals reversed the finding of the District Court and held that there had been four occurrences involved in the claim.¹³⁰ This amounted to one occurrence in each policy period.¹³¹ The Court stated:

[B]ecause each policy covers only damages stemming from [the child's] exposure to the [priest] occurring during the policy period, and because the parties do not contest that [the child] was exposed to the negligently supervised priest in each of the four policy periods, we conclude that [the] claim implicates four occurrences.¹³²

Based on the policy definition of occurrence, the Court found that “the repeated ‘exposure’ of the boy to the negligently supervised priest,” rather than the negligent supervision alone, resulted in injury.¹³³ Also, the court found it significant that the policy only covered injuries arising from occurrences “happening during the period of insurance.”¹³⁴ Therefore, the court concluded that although the child’s injuries arose from the same general conditions, based on the facts, the child’s “exposure to the

¹²⁷ It is important to note that the coverage is not being provided for instances of molestation, but rather for the negligent supervision that facilitated the instances of abuse.

¹²⁸ Cooke, *supra* note 13, at 1056.

¹²⁹ 35 F.3d 1325 (9th Cir. 1994).

¹³⁰ *Id.* at 1331.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.* at 1329.

¹³⁴ *Id.*

negligently supervised priest in each of the four different policy periods constituted a separate occurrence.”¹³⁵

3. The Seventh Circuit

In *Lee v. Interstate Fire & Cas. Co.*,¹³⁶ the court rejected the insurer’s argument that the “continuous exposure” language rendered a priest’s molestation of one child during two policy years and in two distinct places to constitute one occurrence.¹³⁷ The court held that Rhode Island law “would not treat negligent supervision as invariably one ‘occurrence.’”¹³⁸ The court also rejected the analogy of asbestos cases to clergy sexual abuse cases and stated:

The language defining “cause” does not speak directly to this question. It assumes a two-party perspective- that an insured tortfeasor has harmed a victim. Its language is a mismatch for a case in which the tort is negligent supervision of an intentional wrongdoer. “[C]ontinuous or repeated exposure to conditions” sounds like language designed to deal with asbestos fibers in the air, or lead-based paint on the walls, rather than with priests and choirboys. A priest is not a “condition” but a sentient being, and of course the victim was never “exposed” to the Diocese’s negligent supervision.¹³⁹

The court decided neither to rule on the occurrence issue nor remand the case for further findings, claiming that the parties submitted insufficient information to make a determination of the number of occurrences and refusing to make a decision based upon the policy alone.¹⁴⁰ Although it did not formally rule on the issue, the court undermined the analogy between toxic torts and clergy sexual abuse.

¹³⁵ 35 F.3d at 1330; *see also Soc’y of the Roman Catholic Church*, 26 F.3d at 1363-64 (the court reached a similar conclusion on almost identical facts).

¹³⁶ 86 F.3d 101 (7th Cir. 1996).

¹³⁷ *Id.* at 104-05.

¹³⁸ *Id.*

¹³⁹ *Id.* at 104.

¹⁴⁰ *Id.* at 105.

It is...doubtful that the insured could reasonably expect [the toxic tort] language to afford coverage for sexual abuse by church employees. This language clearly contemplates contact with contaminants like asbestos, radiation, or noxious gases (preceded by the insured's neglect, at worst, and where only extended contact produces injury). Stretching such language to cover child molestation (where a single intentional act results in immediate injury) strains logic to the breaking point.¹⁴¹

Courts routinely caution against judicial expansion of insurance coverage to arenas outside the agreed policy terms.¹⁴²

4. Other Jurisdictions

Some jurisdictions have questioned the finding that negligent supervision could amount to an occurrence for general liability insurance purposes. Courts in these jurisdictions do not recognize the negligent supervision of priests on the part of the Church as triggering insurance coverage. "[T]he occurrence is not the Archdiocese's negligent supervision of [the priest] as such, but the 'exposure' of the boy to the negligently supervised priest . . ."¹⁴³ "[E]ach child was 'exposed' to the

¹⁴¹ Cooke, *supra* note 13, at 1057.

¹⁴² See, e.g., *Am. Family Mut. Ins. Co. v. Am. Girl, Inc.*, 673 N.W.2d 65, 73 (Wis. 2004) ("If it is clear that the [insurance] policy was not intended to cover the claim asserted, the analysis ends there."); *Nicholls v. Zurich Am. Ins. Group*, 244 F. Supp. 2d 1144, 1156 (D. Colo. 2003) ("[Under Colorado law,] insurer cannot be held liable beyond the scope of risks which have been clearly covered in the insurance policy."); *Yale Univ. v. Cigna Ins. Co.*, 224 F. Supp. 2d 402, 410 (D. Conn. 2002) ("[Under Connecticut law,] mere absence of specific exclusions, standing alone, does not create coverage where it otherwise does not exist under the express terms of the policy."); *Hallum v. Provident Life & Accident Ins. Co.*, 257 F. Supp. 2d 1373, 1379 (N.D. Ga. 2001) ("To establish a prima facie case on a claim under a policy of insurance, the insured must show the occurrence was within the risk insured against."); *Turner v. State Farm Fire & Cas. Co.*, 112 Cal. Rptr. 2d 277, 283 (Cal. Ct. App. 2001) ("[W]hen an occurrence is clearly not included within the coverage afforded by the insuring clause, it need not also be specifically excluded."); *Bush v. State Farm Fire & Cas. Co.*, 124 F. Supp. 2d 1203, 1205 (D. Or. 2000) ("Under Oregon law, analysis of insurance coverage issues is based on specific terms of the policy, not on the court's general concepts of what coverage various kinds of insurance should provide.").

¹⁴³ *Archdiocese of Portland*, 35 F.3d at 1329.

pedophilic employee, not to [the insured's] negligent employment practices.”¹⁴⁴

Most courts apply the causal test, which encompasses the separate acts of clergy sexual abuse and only recognizes instances where a new person is exposed.¹⁴⁵ These courts count the parish-to-parish relocations as a single occurrence, despite the number of parishioners that were abused by the priest while at a single parish.¹⁴⁶

Additionally, a few courts have required a high level of Diocese awareness to establish that the Church should have known of the high probability of sexual misconduct. In *Diocese of Winona v. Interstate Fire & Cas. Co.*,¹⁴⁷ the court stated that “[t]he issue...is whether a reasonably prudent person in the position of the Diocese...knew or should have known that [the priest's] abuse of [the victim] was substantially probable as a result of the continuing exposure caused by their willful indifference.”¹⁴⁸ The priest accused of sexual abuse in this case had admitted to eight instances of sexual abuse prior to the instance concerning the case at hand.¹⁴⁹ There were reports that the priest had previously attempted to molest a boy on “five or six occasions” and had admitted to the diocese that he had touched the boy.¹⁵⁰ In another instance, the priest told a diocese official that he had asked two boys to disrobe.¹⁵¹ The priest also admitted to the diocese that he had tried to molest a boy in a swimming pool; the priest admitted to touching another boy in a sauna a year later.¹⁵² In that same year, the diocese received allegations that the priest had molested over twenty boys during the past fifteen years, and that at least one child had been molested for over a decade.¹⁵³ In response to these allegations, the Church moved the priest to different churches, insisted the priest take

¹⁴⁴ H.E. Butt Grocery Co. v. Nat'l Union Fire Ins. Co., 150 F.3d 526, 533 (5th Cir. 1998).

¹⁴⁵ See, e.g., *Burge v. Parish of St. Tammany*, No. 912321, 1997 WL 10243, at *20-*21 (E.D. La. Jan. 8, 1997) (In discussing a priest who molested children at a parish for over a decade, the Court stated, “[a]lthough this negligence was present in each of the policy years at issue, it was continuous negligence, and not a number of discrete episodes of negligence.”).

¹⁴⁶ *Id.*

¹⁴⁷ 89 F.3d 1386.

¹⁴⁸ *Id.* at 1391.

¹⁴⁹ *Id.* at 1393.

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ 89 F.3d 1386.

leave of absences, and imposed treatment programs in which the Bishop testified that he “didn’t have any confidence.”¹⁵⁴

The district court found that the diocese “neither expected nor intended the injuries cause by [the priest], and that the abuse therefore constituted an ‘occurrence’ as defined in the insurance policies....”¹⁵⁵ However, after reviewing the numerous reports, considering the failed therapy treatments, parish-to-parish relocations, multiple confessions, the Court of Appeals found that “[a] reasonably prudent person in the position of the diocese should have known there was a substantial probability that [the priest] would continue to sexually abuse children.”¹⁵⁶

B. HOW “BODILY INJURY” HAS BEEN INTERPRETED BY THE COURTS IN CLERGY SEXUAL ABUSE CASES

Commercial general liability insurance policies generally obligate the insurer to pay any legal obligations of the insured due to bodily injury or property damage caused by an occurrence during the policy period.¹⁵⁷ In cases of clergy sexual abuse, courts have interpreted “bodily injury” to refer to actual physical injury, rather than mental or emotional injury.¹⁵⁸ Therefore, a claim arising out of clergy sexual abuse may not fit within the coverage of the insurance policy if it does not allege a physical injury, but only alleges emotional injuries such as humiliation or embarrassment.¹⁵⁹

However, some courts have found emotional injuries to fall within “bodily injury,” and thus within the policy terms. In *Servants of the Paraclete, Inc. v. Great Am. Ins. Co.*,¹⁶⁰ the court found psychological and emotional injuries, such as depression, anxiety, poor self-esteem, and self-

¹⁵⁴ *Id.* at 1393.

¹⁵⁵ *Diocese of Winona v. Interstate Fire & Cas. Co.*, 916 F. Supp. 923, 926 (D. Minn. 1995).

¹⁵⁶ *Diocese of Winona*, 89 F.3d at 1394.

¹⁵⁷ ABRAHAM, *supra* note 74, at 408.

¹⁵⁸ See e.g., *Kline v. Kemper Group*, 826 F. Supp. 123, 129 (M.D. Pa. 1993), *aff’d mem.*, 22 F.3d 301 (3d Cir. 1994) (“The Pennsylvania courts have soundly rejected the contention that policy definitions of injury or bodily injury encompass mental or emotional harm.”) (citing *Jackson v. Travelers Ins. Co.*, 606 A.2d 1384 (Pa. 1992)).

¹⁵⁹ *Lapeka, Inc. v. Sec. Nat’l Ins. Co.*, 814 F. Supp. 1540, 1548-49 (D. Kan. 1993) (finding claims for pain, humiliation, and embarrassment outside the definition of “bodily injury” covered by policy).

¹⁶⁰ 857 F. Supp. 822 (D.N.M. 1994), *modified on other grounds*, 866 F. Supp. 1560 (D.N.M. 1994).

destructive behavior to be covered under a policy that defined "bodily injury" as "bodily injury, sickness or disease."¹⁶¹ Additionally, courts have held that a policy provided coverage for current bodily injuries that were the result of sexual abuse that had taken place years before.¹⁶²

IV. THE AFTERMATH OF LITIGATION

The varying outcomes of cases alleging clergy sexual abuse have had an effect on liability insurance coverage of religious institutions. More and more cases are finding that self-insured retentions are to be used, causing the Diocese themselves to have to pay damage awards awarded to victims of clergy sexual abuse. Additionally, the liability insurance policies of the religious institutions have changed, where sexual abuse is specifically exempted from coverage. This has caused religious institutions to purchase insurance specifically covering sexual abuse. However, this new form of "sexual abuse insurance" remains insufficient to cover the damage awards handed down to victims. Therefore, religious institutions have been forced by insurance companies to increase their efforts to stop the sexual abuse of parishioners by clergy members, as the continuing of both the practice of sexual abuse by clergy members and the turning a blind-eye by the institutions causes large damage awards to come out of the institution's own pocket.

A. HOW HAVE COURTS DEALT WITH SELF-INSURED RETENTIONS WHEN DAMAGES ARE AWARDED IN CLERGY SEXUAL ABUSE CASES

The determination of how a court will deal with a self-insured retention in each policy period can significantly affect the parties' financial responsibilities for damages. How a party is financially affected by a court's treatment of self-insured retentions is best understood through this scenario: A claim was brought in which there was five years of abuse, and the case was settled for \$500,000. The diocese had five one-year policies, each with a \$100,000 self-insured retention. How the court deals with these self-insured retentions determine whether the diocese would be

¹⁶¹ 857 F. Supp. at 834.

¹⁶² See *Milbank Ins. Co. v. J.T.*, No. C7-96-1225, 1997 WL 10525 (Minn. App. Ct. Jan. 14, 1997) (finding that the time of "occurrence" is not necessarily when the act was committed, but rather when the individual was actually damaged).

responsible for \$100,000 in damages or the whole claim. Based on the court's decision in *Diocese of Winona v. Interstate Fire & Cas. Co.*,¹⁶³ the diocese would be responsible for the entire damage award.

In *Diocese of Winona v. Interstate Fire & Cas. Co.*,¹⁶⁴ the court held that the Church was responsible for the self-insured retention for "each of the triggered policies."¹⁶⁵ The court had previously determined that the churches were liable only for a single, weighted self-insured retention; however, the court changed their decision in light of an intervening decision of the Minnesota Supreme Court.¹⁶⁶ The court in *Winona* concluded that the two cases were "factually indistinguishable,"¹⁶⁷ and stated:

Each litigation involved indemnification under [comprehensive general liability] policies that contained a layer of self-insurance (the SIR) for which the insured was responsible. Each involved injuries incurred over an extended period of time, a period during which the insured was covered by a number of distinct insuring agreements. And, each involved damages that could not rationally be allocated to specific policy periods in which the damages actually occurred.¹⁶⁸

Based on this reasoning, the court concluded that the diocese had to pay the entire damage award.¹⁶⁹

Additionally, in *Interstate Fire & Cas. Co. v. Archdiocese of Portland in Oregon*,¹⁷⁰ the Archdiocese argued that a finding that abuse constituted more than one occurrence would be contrary to public policy because "such a finding would require the Archdiocese to pay more than one [self-insured retention]."¹⁷¹ The court rejected this argument because although the Archdiocese would have to bear a significant burden of the

¹⁶³ 916 F. Supp. 923, 929.

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* at 929.

¹⁶⁶ *Id.* at 926 (relying upon *N. Power Co. v. Fid. & Cas. Co. of N.Y.*, 523 N.W.2d 657 (Minn. 1994) (a case involving continuous environmental contamination)).

¹⁶⁷ *Id.* at 928.

¹⁶⁸ *Id.*

¹⁶⁹ 916 F. Supp. 929.

¹⁷⁰ 35 F.3d 1325.

¹⁷¹ *Id.* at 1331.

settlement, this was “dictated by the terms of the policies the Archdiocese purchased.”¹⁷² The court did not reach the issue of how the damages should be apportioned among the four insurance policies at issue in this case.

B. HOW INSURANCE POLICIES FOR THE CATHOLIC CHURCH
HAVE CHANGED IN THE AFTERMATH OF THE SEXUAL ABUSE
SCANDAL

After courts began to interpret insurance policy language to find ways to award clergy sexual abuse victims damages, insurance companies began to take more express measures to ensure that they would not be responsible for large amounts of damages awarded to clergy sexual abuse victims.¹⁷³ These measures have ranged from expressly excluding insurance coverage for claims arising out of the sexual abuse by clergy¹⁷⁴ to limiting insurance company liability for claims arising out of clergy sexual abuse. Additionally, after being blind-sided by the claims arising after the Gauthre case, insurance companies began to offer religious institutions policies specifically covering clergy sexual abuse claims.¹⁷⁵

1. Exclusions from Coverage

In the aftermath of the sexual abuse scandal, some insurance companies extending coverage to religious institutions have expressly excluded coverage for claims “arising out of” abuse or molestation.¹⁷⁶ This express exclusion will obviously prevent coverage being found for claims arising out of clergy sexual misconduct, the “arising out of” language has

¹⁷² *Id.*

¹⁷³ “[S]ince 1982, American dioceses have lost more than \$400 million in legal and medical costs because of sexual misconduct.” In addition, the New Mexico archdiocese faced “\$50 million in liability suits” in the 1990’s. O’Reilly & Strasser, *supra* note 10, at 32-33.

¹⁷⁴ LYTTON, *supra* note 14, at 77.

¹⁷⁵ *Id.* at 76-77.

¹⁷⁶ See, e.g., *McAuliffe*, 69 F.3d at 279 (affirming district court’s decision that the abuse and molestation exclusion precluded coverage for claims of tortious conduct against priest and claim of negligent supervision against Bishop); *Hough v. State Farm Fire and Cas. Co.*, 481 N.W.2d 393, 397-98 (Minn. Ct. App. 1992) (finding no duty to defend because sexual abuse exclusion precluded claims of negligent counseling which were based on sexual relationship between pastor and parishioner).

also been found to preclude claims for negligent hiring and supervision or retention of the abuser.¹⁷⁷ These claims of negligence on the part of the Church are excluded from “arising out of” abuse due to the fact that the sexual abuse is found to be an essential element of these claims.¹⁷⁸

2. Limitations on Coverage

While some policies have expressly excluded claims arising from sexual abuse from their coverage, some others have set lower limits on such claims. One policy included, in its “Sexual Misconduct” provision, a cap on liability for psychotherapists at \$25,000 for “all claims against any Insured(s) involving any actual or alleged erotic physical contact, or attempt thereat [sic] or proposal thereof by the insured with his or her former or current patient.”¹⁷⁹ This cap was considered to apply to other claims arising out of the professional relationship if sexual misconduct was alleged.¹⁸⁰ The provision limiting liability relates to clergy sexual abuse cases because the psychotherapist-patient and clergy-parishioner relationship are usually considered to be analogous. Both the psychotherapist and the clergy member can be seen to have a therapeutic role in relation to the patient or parishioner, respectively.

These types of limitations have been challenged in cases as violating public policy. However, this argument has had mixed results. The Seventh Circuit has rejected arguments that a limitation for liability for sexual misconduct claims violates public policy.¹⁸¹ Yet, the Ninth Circuit has affirmed a decision finding that a provision limiting liability for sexual misconduct is void as against public policy.¹⁸² In finding the cap void, the court reasoned that it caps liability on non-sexual misconduct claims when sexual misconduct claims are also involved.¹⁸³

¹⁷⁷ See, e.g., *IPCI Ltd. v. Old Republic Ins. Co.*, 758 F. Supp. 478, 480 (E.D. Wis. 1991) (sexual abuse exclusion precluded coverage for claims of negligent supervision against nursing facility where patient was sexually abused).

¹⁷⁸ See *All Am. Ins. Co. v. Burns*, 971 F.2d 438, 442 (10th Cir. 1992) (sexual molestation by volunteer bus driver was an essential element of negligence claims against church and its directors).

¹⁷⁹ *Am. Home Assurance Co. v. Stone*, 61 F.3d 1321, 1323 (7th Cir. 1995).

¹⁸⁰ See *id.*

¹⁸¹ *Id.* at 1328 (noting that the provision was approved by the Illinois Department of Insurance).

¹⁸² See *Am. Home Assurance Co. v. Cohen*, 815 F. Supp. 365, 370-71 (W.D. Wash. 1993), *aff’d mem.*, 67 F.3d 305 (9th Cir. 1995).

¹⁸³ *Id.*

3. Clergy Sexual Abuse Insurance Policies

In the early 1990s, after a period of excluding coverage for acts of sexual misconduct completely, insurance companies began to offer coverage for clergy sexual abuse.¹⁸⁴ However, these policies were subject to many conditions and, in effect, provided little coverage to the religious institutions.¹⁸⁵ Examples of conditions imposed on the policies include an exclusion for claims involving a “previously identified perpetrator” or an exclusion for instances of abuse occurring before a certain date.¹⁸⁶ In addition, low limits may be imposed on the amount of coverage and some insurance companies require religious institutions to “implement risk management programs that include policies for screening personnel, guidelines for interacting with children, and procedures for investigating and responding to allegations.”¹⁸⁷ Because of the conditions imposed on the sexual misconduct policies, coverage for religious institutions is usually not adequate.¹⁸⁸ These actions by the insurance companies in the aftermath of the Catholic Church sexual abuse scandal have had a regulating effect on religious institutions and how they approach clergy sexual misconduct.

¹⁸⁴ LYTTON, *supra* note 14, at 77.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ “The National Catholic Risk Retention Group, which is comprised of sixty-four dioceses and archdioceses, rejects the overwhelming majority of claims made by its members.” *Id.* Bemis, the president and CEO, states that:

[O]f all of the sexual misconduct claims that have been reported to us historically, on average in any given year, in excess of 90 percent- most recently the average was about 93 percent- will be denied by us. And that is a function of the claims being pre-retro to us [i.e., based on abuse that occurred prior to 1988 and therefore excluded from coverage] . . . or . . . it was clear that the diocese had knowledge but did not report to us within the 120 days that our forms stipulate to report the claim to us or because we’re an excess carrier and we don’t [cover the first] \$250,000 of loss from ground, . . . and the claim . . . is just not big enough to get to us.

Id.

V. HOW LIABILITY INSURANCE COMPANIES HAVE
REGULATED RELIGIOUS INSTITUTIONS IN THE
AFTERMATH OF THE CATHOLIC CHURCH SEXUAL
ABUSE SCANDAL

The evolution of liability insurance policies throughout the Catholic Church sexual abuse scandal has shed light on how the insurance companies issuing liability insurance to religious institutions have regulated their behavior. Because of the transition from general insurance policies that courts interpreted to find coverage for acts of clergy sexual misconduct to the explicit exclusion of these acts from general liability insurance policies, religious institutions have been forced to seek additional insurance to cover possible acts of sexual abuse of their clergy. Yet, even with the added coverage, acts of sexual abuse are still more likely than not to not be covered by these policies, due to the many conditions and exclusions placed on the policy.¹⁸⁹ As a result, religious institutions have oftentimes been forced to bear the burden of judgments themselves.¹⁹⁰ As the cost of judgments climbs higher, the religious institutions are forced to take a more proactive effort in reducing the acts of clergy sexual abuse. Additionally, in granting insurance coverage, insurance companies themselves are insisting on reformed policies aimed at curtailing the occurrences of clergy sexual misconduct.¹⁹¹ As a result, a greater emphasis on reform within the Church has arisen and policy, such as personnel screening and strict guidelines for dealing with children, has been implemented to prevent acts of clergy sexual misconduct from continuing.¹⁹² The move toward discouraging Church officials from covering up acts of clergy sexual abuse is definitely a much-needed reform, and while it is hard to believe acts of clergy sexual abuse has stopped because of these policy changes, it seems like a move in the right direction towards eradicating them. As judgments against the Church rise, and insurance companies craft new ways to avoid paying for them, we will see even more reform aimed at curtailing clergy sexual abuse until it does become a thing of the past.

¹⁸⁹ LYTTON, *supra* note 14, at 77.

¹⁹⁰ “Current estimates indicate that of the more than \$2.6 billion paid by the Church in response to clergy sexual abuse claims, less than 30 percent was covered by insurance.” *See id.* at 78.

¹⁹¹ *See id.* at 77.

¹⁹² *See id.* at 78.

CONCLUSION

The evolution of liability insurance policies for religious institutions, as a result of the Catholic Church sexual abuse scandal, has been the result of the widespread problem of clergy sexual abuse. However, the resulting lawsuits by the victims caused the liability insurance carriers of religious institutions to craft conditions and exceptions to policies, and placed the majority of the liability for the acts of clergy sexual misconduct in the hands of the religious institutions. Religious institutions, like the Catholic Church, , prompted either by liability insurance companies or on their own accord, were forced to make drastic policy changes to avoid the resulting liability from lawsuits of clergy sexual abuse victims. In this way, liability insurance companies incentivized religious institutions to implement policies to curb clergy sexual misconduct. While these policies may not yet have completely eradicated the problem of clergy sexual abuse, continuing liability as a result of exclusions and restrictions within liability insurance policies combined with expansive policies aimed at preventing clergy sexual misconduct could make this abuse a thing of the past.

COVERAGE FOR KIDNEYS: THE INTERSECTION OF INSURANCE AND ORGAN TRANSPLANTATION

*Melissa Wong**

INTRODUCTION

At its best, the medical practice of organ transplantation demonstrates the most gracious qualities of generosity and sacrifice, where a decision by a living organ donor or a deceased donor's grieving family can mean the difference between a second chance at life or years spent waiting before time runs out. Fundamentally, organ transplantation also remains a stark example of the classic economic theory of supply and demand. Despite medical advancements, the growing acceptance of organ donation, and policy efforts to increase the donation rate, the waiting list of potential recipients grew 64% over the past ten years while the number of donors rose by only 39% during that same span of time.¹ More than 100,000 individuals are listed currently on the national organ transplant registry.² Last year alone, 6,453 candidates died waiting for an organ donor match, or an average of 18 patients per day.³ For these reasons, the life and death decisions behind how to allocate available organs for transplantation must be sensitive to the ethical and policy interests of objectivity, efficiency and fairness.

The health insurance sector plays a critical role in the organ transplantation specialty. Insurance may interact with this medical field in ways which yield significant benefits, assisting patients in funding otherwise prohibitively expensive procedures or setting appropriate

* J.D., University of Connecticut School of Law, 2010; B.A., University of Pennsylvania, 2001. I would like to thank Professor Susan Schmeiser for her valued input as well as my family and friends for their support and encouragement. This Note is dedicated to my father, Jerry Wong, a healthy kidney transplant recipient since 1991.

¹See U.S. DEP'T HEALTH & HUMAN SERV., OPTN/SRTR ANNUAL REPORT app. at 1-1, 1-3 (2008).

² United Network for Organ Sharing, <http://www.unos.org> (last visited Mar. 10, 2010).

³ Organ Procurement and Transplantation Network, <http://optn.transplant.hrsa.gov> (select "View Data Reports," "National Data," "Waiting List Removals" in Step 1 drop-down menu; then follow "Death Removals by UNOS Status by Year" hyperlink in Step 2) (last visited Mar. 10, 2010).

standards of care in this practice. Still, insurance coverage issues also tend to expose glaring disparities with how organs are allocated among potential recipients based on the ability to pay for these life-saving procedures.

This Note examines both the positive and negative consequences which result when insurance matters intersect with the practice of organ transplantation. Part I summarizes the medical developments behind organ transplantation and subsequent legislative efforts to support the infrastructure and health policies of this field. Part II examines the primary forms of insurance coverage for both organ donors and recipients and the most commonly litigated issues which arise based on each funding option. Part III then addresses the unexpected and unintended connections formed as a result of this interaction, such as the correlation between insurance status and the likelihood of receiving or donating an organ. Finally, Part IV proposes recommendations to promote the beneficial interplay between insurance and organ transplantation while minimizing the more negative effects of the relationship.

I. MEDICAL AND LEGISLATIVE HISTORY OF ORGAN TRANSPLANTATION

While the earliest attempts at organ and tissue transplantation date back thousands of years, the era of modern transplant surgery has been established only in the past few decades.⁴ In 1954, the kidney was the first major organ to be transplanted successfully, followed rapidly by the first transplants for the pancreas, heart and liver all within the next fifteen years.⁵ Further advancements stalled due to the complications of future organ rejection, but with the development of Cyclosporine and other anti-rejection immunosuppressive drug therapies in the 1970s and 1980s,⁶ as well as other surgical improvements such as the use of laparoscopic or single-incision techniques, the practice of organ transplantation has grown to include lung and intestinal transplants, dual organ transplants, artificial or animal organ transplants, stem-cell transplants, and most recently, face,

⁴ Laurence A. Turka, M.D., *Historical Overview*, PRIMER ON TRANSPLANTATION 1 (2nd ed. 2001).

⁵ UNITED NETWORK FOR ORGAN SHARING, UNOS FACTS AND FIGURES 4, <http://www.unos.org/resources/brochure>.

⁶ Jed Adam Gross, *E Pluribus Unos: The National Organ Transplant Act and Its Postoperative Complications*, 8 YALE J. HEALTH POL'Y, L. & ETHICS 145, 170 (2008). With the introduction of cyclosporine therapy, one-year kidney transplant survival rates climbed from 55% from 85% while five-year liver transplant survival rates increased from 18.2% to 68%. *Id.*

limb and ovary transplantation.⁷ Today, more than 250 medical facilities across the United States perform major organ transplant procedures at a rate of 27,000 per year.⁸

A. THE UNIFORM ANATOMICAL GIFT ACT

Shortly after the first successful heart transplant procedure and as major organ transplantation became more commonplace, the National Conference of Commissioners on Uniform State Laws established the Uniform Anatomical Gift Act (UAGA) in 1968.⁹ The UAGA represents the first attempt to codify in some form the standards and guidelines for the donation and receipt of anatomical gifts. The UAGA provides that any individual aged eighteen years or more, may give all or any part of his or her body upon death for any purpose specified in the Act.¹⁰ This is a right that was not clearly recognized in common law at the time.¹¹ The UAGA also mandates that surgeons remove the gifted organ “without unnecessary mutilation”¹² and that the time of death of the potential donor be determined by a physician who does not participate in the transplant procedure itself.¹³ This stipulation is intended to combat fears that overeager doctors could declare brain or cardiac death prematurely in the hopes of salvaging organs for donation.¹⁴ The UAGA also exempts from criminal or civil liability a hospital, physician, public health officer or other person who acts in good faith in accordance with the terms of the Act or a similar anatomical gift statute of another state or foreign country,¹⁵ presumably in the public interest of encouraging medical professionals to

⁷ See, e.g., UNOS FACTS AND FIGURES, *supra* note 5; Lawrence K. Altman and Anahad O'Connor, *Cleveland Clinic Gets Victim of Chimp Attack*, N.Y. TIMES, Feb. 20, 2009, at A26; Jon W. Jones, M.D. et al., *Successful Hand Transplantation: One-Year Follow-Up*, NEW ENG. J. MED. 468 (Aug. 17, 2000); Robert Dobson, *Ovarian transplant raises hope for women facing cancer treatment*, 319 BRIT. MED. J. 871 (Oct. 2, 1999).

⁸ UNOS FACTS AND FIGURES, *supra* note 5, at 1, 10; United Network for Organ Sharing, *supra* note 2.

⁹ UNIF. ANATOMICAL GIFT ACT, at p. 3 (amended 2009).

¹⁰ *Id.* § 4.

¹¹ *Id.* at p. 3.

¹² *Id.* § 14(h).

¹³ *Id.* § 14(i).

¹⁴ See *id.* at p. 3.

¹⁵ See *id.* § 18.

participate in the removal of organs after death for the purpose of donation.¹⁶

While all jurisdictions had enacted into state law the Uniform Anatomical Gift Act of 1968, only twenty-six states adopted the later 1987 revisions to the UAGA.¹⁷ Several states have since incorporated their own non-uniform amendments to original statutes.¹⁸ As a result, there is significance divergence in previously consistent state anatomical gift laws, posing a serious impediment to organ transplant processes extending beyond state lines. Since only a short window for transplantation exists, as brief as four to six hours for a heart or lung,¹⁹ there may not be enough time for extensive research into and compliance with each state's policy. The UAGA has been revised again in 2006 and 2009 in attempts to re-secure more uniform adoption across the states and to align more closely with federal laws regulating organ transplantation.²⁰ Thirty-seven states have enacted this latest set of revisions to the Uniform Anatomical Gift Act, with five more states scheduled to introduce the bill in 2010.²¹

B. THE NATIONAL ORGAN TRANSPLANT ACT

The National Organ Transplant Act (NOTA) of 1984 sets federal guidelines for organ donation and transplantation. Congress enacted NOTA to address the growing competition for donor organs and the unequal distribution of available organs.²² The Act set a new national health policy to ensure the equitable allocation of organs through the

¹⁶ See *Williams v. Hoffman*, 223 N.W.2d 844, 848–49 (Wis. 1974) (stating that the “limitation on liability ... is justified by the legitimate public purpose of encouraging doctors to participate in the removal of organs following death, and therefore increasing their supply.”). See also *Ramirez v. Health Partners of Southern Ariz.*, 972 P.2d 658, 666 (Ariz. 1998) (“There is a critical state interest in encouraging organ donation and protecting procurement personnel who engage in that important work.”).

¹⁷ UNIF. ANATOMICAL GIFT ACT, at p. 1 (amended 2009).

¹⁸ *Id.*

¹⁹ UNITED NETWORK FOR ORGAN SHARING, PARTNERING WITH YOUR TRANSPLANT TEAM: THE PATIENT'S GUIDE TO HEALTH 10, <http://www.unos.org/resources/brochures.asp>. For example, the liver or pancreas lasts for 12-24 hours and the kidney up to 72 hours. *Id.*

²⁰ See UNIF. ANATOMICAL GIFT ACT, at p. 4 (amended 2009).

²¹ Uniform Anatomical Gift Act, <http://anatomicalgiftact.org/DesktopDefault.aspx> (follow “Enactment Status”).

²² See United Network for Organ Sharing, *supra* note 5, at 5; National Organ Transplant Act, 42 U.S.C. § 273-74 (2000).

establishment of a national organ procurement and transplantation network, while at the same time working to increase the overall number of organs available for transplantation.²³ The Act also authorized funding for fifty-nine regional Organ Procurement Organizations (OPOs) to consolidate and coordinate donation efforts and help foster public awareness about the critical need for organ donors.²⁴ Finally, NOTA expressly forbids the buying and selling of human organs and body parts, imposing up to a \$50,000 fine or five years imprisonment for organ trafficking and other actions to commercialize the donative process.²⁵

Prior to the enactment of NOTA, private regional transplant networks managed the donor matching process but were limited by strict regional borders and a lack of coordination across systems.²⁶ As a result, medical facilities in some areas were forced to compete for available organs while in other localities, donor organs went unused.²⁷ NOTA authorized the creation of a centralized Organ Procurement and Transplantation Network (OPTN) to better facilitate organ matching, delivery, and transplant surgeries.²⁸ Congress contracted with a private entity, the United Network for Organ Sharing (UNOS), to oversee this network in the hopes that management by a private entity would be the fastest method to establish nationwide coordination given bureaucratic delays with federal ownership and the initiative of the private sector in establishing original networks in the first place.²⁹

UNOS is responsible for coordinating organ transplant efforts among 58 organ procurement organizations (OPOs) and 250 hospital and medical facilities which maintain organ transplant programs.³⁰ UNOS also formulates the network's membership criteria and the ensuing medical standards for transplant procedures.³¹ Each hospital with a transplant program is a member of the OPTN and must adhere to the standardized

²³ See National Organ Transplant Act, 42 U.S.C. § 273-74 (2000); R. R. Bollinger et al., *Organ Procurement Organization (OPO), Best Practices*, 15 CLINICAL TRANSP. 16 (2001).

²⁴ *Id.* § 273(a).

²⁵ *Id.* § 274(e).

²⁶ United Network for Organ Sharing, *supra* note 2.

²⁷ *Id.*

²⁸ National Organ Transplant Act, 42 U.S.C. § 274 (2000).

²⁹ See UNITED NETWORK FOR ORGAN SHARING, *supra* note 5, at 5.

³⁰ UNITED NETWORK FOR ORGAN SHARING 2009 ANNUAL REPORT 3, 18, <http://www.unos.org/docs/AnnualReport2009.pdf>.

³¹ *Id.* at 4.

criteria for patient eligibility and wait-list priority.³² Eligibility and priority factors include the degree of medical compatibility between the donor and donee and the urgency for medical intervention.³³ The patient's location is also an important consideration, since decreased transfer time leads to better preservation of the organ and better survival rates.³⁴ Additionally, the network measures the amount of time a donee spends on the waiting list to determine priority over other potential recipients.³⁵ In certain cases, the highest-ranked patient on the waiting list may be passed over if the individual cannot be located, is temporarily sick, would likely reject a transplanted organ, or would benefit only minimally from the procedure because of age or medical condition as determined by his or her transplant team.³⁶

C. ORGAN TRANSPLANTATION TODAY

As thousands of patients join the organ transplant list each year, the continual shortage of available organs lingers as a major challenge despite widespread efforts to increase the rates of donation.³⁷ Some of the reasons behind diminished donation numbers are attributable to positive medical advancements, such as more rigorous medical screening processes, an overall decrease in accidental death, and the increase in survival rates for infants delivered prematurely.³⁸ Other explanations reflect problems which

³² See Organ Procurement and Transplant Network Policy 1 on Member Rights and Obligations, <http://optn.transplant.hrsa.gov/policiesAndBylaws/policies.asp>.

³³ See Organ Procurement and Transplant Network Policies 3.2-3.4 on Organ Distribution UNOS Patient Waiting List, Acceptance Criteria, and Organ Procurement, Distribution and Allocation, <http://optn.transplant.hrsa.gov/policiesAndBylaws/policies.asp>

³⁴ *Id.*

³⁵ *Id.*

³⁶ See *id.*

³⁷ Additional efforts to promote organ donation include the Organ Donation Insert Card Act, which established a national initiative through the Department of Health and Human Services to increase donation by 20% by 2000 and authorized the mailing of organ donor cards along with income tax refunds. Organ Donation Insert Card Act, Pub. L. No. 104-91 (1996).

³⁸ See Raja B. Khauli, *Issues and Controversies Surrounding Organ Donation and Transplantation: The Need for Laws That Ensure Equity and Optimal Utility of a Scarce Resource*, 27 SUFFOLK U. L. REV. 1225, 1226 (1993); see also Mark F. Anderson, *The Future of Organ Transplantation: From Where Will New Donors Come, To Whom Will Their Organs Go?*, 5 HEALTH MATRIX 249, 278 (1995).

have plagued the donation process for decades, including common scenarios where potential donors fail to sign directives or medical personnel neglect to search for donor cards, leaving the decision in the hands of family members who may refuse consent or are unaware of the patient's wishes.³⁹ Meanwhile, the demand for organs continues to grow. To cite just one statistic, the national diagnosis rate for diabetes, a leading cause of kidney failure, has increased from 2.7% in 1985 to 5.5% in 2005 and will continue to rise based on obesity, aging and ethnic demographic trends.⁴⁰

Still, there is little to justify the overwhelming deficit in the overall number of donors. Almost every religion supports organ donation as consistent with its beliefs, though some may not be aware of their particular religion's support for the practice or instead experience general reluctance to donate based on other principles.⁴¹ Non-traditional donors, such as living donors and donors over 50 who would have been previously ineligible to donate due to age, are compensating for lower donation rates elsewhere. For example, the number of living donors increased by 245% over the past twenty years, while donors aged 50 and older increased by 456% over the same period of time.⁴² Comparatively, the average rate of growth in the amount of all donors increased only by 125% overall.⁴³ Additionally, hospitals are evaluating new protocols which allow for organ donation after cardiac death instead of brain death, creating an expanded class of donors beyond the diminishing number of eligible brain-dead patient-donors.⁴⁴

³⁹ Andrew C. MacDonald, *Organ Donation: The Time Has Come to Refocus the Ethical Spotlight*, 8 STAN. L. & POL'Y REV., Winter 1997, at 177, 180 (1997).

⁴⁰ Gross, *supra* note 6, at 241.

⁴¹ Summary Statements of Various Religious Groups About Organ and Tissue Donation, <http://www.unos.org/news/newsDetail.asp?id=236> (last visited Mar. 10, 2010); *see also* Larissa MacFarquhar, *The Kindest Cut*, NEW YORKER, July 27, 2009, at 39 ("Reluctance that many feel toward donating organs, even after death, is not selfishness or superstition but a sign that our sense of body as something whole, something human, something sacred has not yet withered.").

⁴² Organ Procurement and Transplantation Network, <http://optn.transplant.hrsa.gov> (select "View Data Reports," "National Data," "Waiting List Removals" in Step 1 drop-down menu; then follow "All Donors By Donor Type" hyperlink in Step 2) (last visited Mar. 10, 2010).

⁴³ *Id.*

⁴⁴ Darshak Sanghavi, *When Does Death Start?*, N.Y. TIMES, Dec. 20, 2009, at MM38.

Even without incorporating new subsets of organ donors, according to the medical and ethical standards set by the National Organ Transplant Act, current donor eligibility guidelines are in fact expansive enough to include 13,091 patients who died under the age of 70 and were otherwise eligible for donation in 2005.⁴⁵ Of that subset, only 58%, or 7,593 patients, became actual donors, generating a supply of over 23,000 organs for transplantation.⁴⁶ Living donors, primarily for the donation of a kidney, contributed about 6,800 more organs to yield a combined total of about 28,000 organs transplanted that year.⁴⁷ This data suggests that there were still 5,498 eligible individuals who died in 2005 without donating their organs upon death.⁴⁸ That number of individual donors would have generated 17,000 additional organs for transplantation, more than enough to make up for the deficits in our donated organ supply.⁴⁹

II. INSURANCE COVERAGE AND ORGAN TRANSPLANTATION

The following section will focus on private and government-funded insurance options for organ donors and recipients. While private insurers serve as major sources of funding for organ transplant procedures, disputes between insurers and insureds often arise due to ambiguities in policy language which dictate coverage or professional disagreement in the health care and insurance sectors as to whether a certain transplant procedure should be covered given its experimental nature or predicted success rate. In addition, government benefit programs like Medicaid and Medicare come with its own host of conflicts, including whether the federal government or the state may set its own coverage criteria in jointly funded and administered programs. Ultimately, the affected parties are forced to balance legitimate concerns of cost and funding health care for the masses with the most intrinsic ideals of saving the life of one identifiable human being.

⁴⁵ NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS, UNIF. ANATOMICAL GIFT ACT, at p. 6 (amended 2009), *available at* <http://www.anatomicalgiftact.org/DesktopDefault.aspx?tabindex=1&tabid=63>.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

A. PRIVATE OR EMPLOYER-BASED INSURANCE

As the court in *Delmarva Health Plan v. Aceto*⁵⁰ notes, insurers “must make difficult, and at times excruciating, decisions about which medical services to cover.”⁵¹

It is a regrettable reality that the more extensive the coverage that is provided under a health insurance policy, the higher the cost of that policy and the fewer individuals who can afford to purchase it. The question of how to balance this tension between access and adequacy is an enormous one with which health insurers and our society as a whole grapple.⁵²

Organ transplants are expensive. A heart transplant can cost up to \$300,000.⁵³ Lung or liver transplants come in at \$250,000 per procedure while a kidney transplant is priced at \$100,000.⁵⁴ The cost of a bone marrow transplant, a procedure with its own extensively litigated body of case law, is estimated at around \$500,000.⁵⁵ In some cases, a patient must provide a down payment or prove coverage that guarantees payment even before he or she can be listed on the active transplant list.⁵⁶

1. Express Coverage

Most insurers provide coverage for traditional organ transplant procedures, even if they are not expressly listed as covered benefits, as long as the treatments are considered medically necessary and non-experimental. For example, in *Aceto*, a Delaware court held that an insured’s lung transplant was an included benefit even though the health insurance policy listed coverage only for kidney, bone marrow and cornea transplants.⁵⁷ While the insurer argued for the maxim *inclusio unius est exclusio*, asserting that the inclusive list for organ transplant coverage automatically

⁵⁰ 750 A.2d 1213 (Del. Ch. 1999).

⁵¹ *Id.* at 1218.

⁵² *Id.*

⁵³ United Network for Organ Sharing, *supra* note 2.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ See, e.g., *Montoya v. Johnston*, 654 F. Supp. 511 (W.D. Tex. 1987); see also *Ellis ex rel. Ellis v. Patterson*, 859 F.2d 52 (8th Cir. 1998).

⁵⁷ *Delmarva Health Plan v. Aceto*, 750 A.2d 1213, 1216 (Del. Ch. 1999).

excludes items not on the list, the court instead found the lung transplant, “a medically necessary, non-experimental, surgical procedure,” falls within the policy’s broader definition of covered services.⁵⁸

At the same time, private insurers have no obligation to provide coverage if it is specifically excluded, even if the transplant is determined to be medically necessary. In *Hawaii Medical Serv. Assoc. v. Adams*,⁵⁹ the health insurer denied coverage for an allogenic stem-cell transplant to treat the insured’s multiple myeloma.⁶⁰ Policy guidelines specifically classified the use of this procedure as “investigational” when used as a treatment for multiple myeloma, though the therapy would be covered by the insurance policy if used to treat a listed set of other conditions.⁶¹ The court in *Adams* held that if the language of the plan “‘specifically excluded’ from coverage the requested allo-transplant for treatment of . . . multiple myeloma,” the insurer had “no obligation to provide coverage.”⁶² Here, the insurer successfully claimed *inclusio unius est exclusio* where this argument failed in *Aceto*. If the insurer were required to list every special medical exclusion instead of including only the conditions that the policy would cover, then the insurer would have to list “every conceivable medical condition for which coverage for allo-transplants would be excluded,” an expectation the court found neither “practical” nor “reasonable.”⁶³

2. Contract Ambiguities

Where policy exclusions and inclusions are not as specific, insureds challenging coverage decisions argue that, according to *contra proferentem*, ambiguities in the policy language are construed against the insurer and in favor of the insured, since the insurer drafts the language and “must suffer the costs of its own drafting imprecision.”⁶⁴

In *Simkins v. NevadaCare, Inc.*,⁶⁵ the insured sought coverage for high-dose chemotherapy with peripheral stem cell rescue (HDC/PSCR) as a treatment for breast cancer.⁶⁶ As part of the HDC/PSCR procedure, stem

⁵⁸ *Id.*

⁵⁹ 209 P.3d 1260 (Haw. Ct. App. 2009).

⁶⁰ *Id.* at 1263. During an allogenic stem-cell transplant, stem cells from a matched donor are harvested and transplanted into the recipient. *Id.*

⁶¹ *Id.* at 1263–65.

⁶² *Id.* at 1268.

⁶³ *Id.* at 1271.

⁶⁴ *Delmarva Health Plan, Inc. v. Aceto*, 750 A.2d 1213, 1218 (Del. Ch. 1999).

⁶⁵ 229 F.3d 729 (9th Cir. 2000).

⁶⁶ *Id.* at 731–32.

cells are harvested and filtered as blood is drawn from the patient's body and later reintroduced in the system after chemotherapy, in the hope that the stem cells will grow to produce healthy red and white blood cells and platelets.⁶⁷ While the insurance policy included coverage for the administration of blood and blood plasma and chemotherapy, the only transplants approved for coverage under the policy were for heart, kidney, cornea, liver, and tissue transplants limited to allogenic bone marrow only.⁶⁸ The court in *Simkins* found that a "person of average intelligence and experience" would not understand stem cells to be tissue under the policy's tissue transplant exclusion.⁶⁹ Instead, the court believed the average person would consider stem cells to be a component of the patient's blood. Especially since the policy "specifically discusses blood transfusions separately from tissue transplants and places tissue transplant coverage within the organ transplant section," the policy retained the "distinct potential of misleading and confusing average plan participants" (emphasis omitted).⁷⁰ "[T]he insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence."⁷¹

On the other hand, in *Hilliard v. BellSouth Medical Assistance Plan*,⁷² the court refused to find a similar insurance policy description ambiguous.⁷³ The insured was diagnosed with multiple myeloma and sought coverage for an autologous bone marrow transplant (ABMT), where the patient's own bone marrow is extracted for reinfusion.⁷⁴ Similar to *Simkins*, the insurance policy only covered cornea, heart, kidney and bone marrow transplants, further specifying coverage for autologous bone marrow transplants in the treatment of three specific conditions: Hodgkin's disease in individuals where conventional therapy has failed, resistant non-Hodgkin's lymphomas, and acute leukemia in remission but with a high probability of relapse.⁷⁵ The court in *Hilliard* agreed with the plan

⁶⁷ *Id.* at 732.

⁶⁸ *Id.*

⁶⁹ *Id.* at 735.

⁷⁰ *Id.*

⁷¹ *Simkins*, 229 F.3d at 736 (quoting *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (9th Cir. 1990)).

⁷² 918 F. Supp. 1016 (S.D. Miss. 1995).

⁷³ *Id.* at 1024-25.

⁷⁴ *Id.* at 1019-20.

⁷⁵ *Id.* at 1020.

administrator that the plan provided coverage only for these three conditions and that multiple myeloma was “simply not covered.”⁷⁶ It also noted that the insured’s employer offered a Supplemental Transplant Assistance Plan at a nominal premium for the purpose of providing additional coverage for autologous transplants and other medical procedures not covered by the primary plan.⁷⁷

B. MEDICARE AND MEDICAID

Government benefits programs, including Medicare and Medicaid, may be used to finance an organ transplant procedure. Medicare is a federally run program that provides health insurance coverage to individuals who are age 65 and older as well as individuals who meet other special criteria, including patients who suffer end-stage renal disease (ESRD) and require either dialysis or a kidney transplant.⁷⁸ Medicaid is a cooperative program between the federal government and individual states to fund certain health care expenses for low-income or disabled persons who qualify.⁷⁹ The state pays medical facilities for health care provided to those eligible under Medicaid.⁸⁰ The federal government subsequently reimburses the state for a substantial portion of that outlay as long as the state is compliant with federal statutory and regulatory requirements.⁸¹

1. State Discretion in Medicaid-Funded Organ Transplants

While the federal government may set broad policies and ensure state compliance with the Medicaid statute, it is up to the states to develop state eligibility and coverage criteria subject to federal approval and reimbursement.⁸² For instance, the Medicaid statute was amended in 1985 to include specific organ transplant criteria that states were required to adopt in order to receive for federal financial assistance for these types of procedures.⁸³ Under this provision, the federal government will not

⁷⁶ *Id.* at 1023.

⁷⁷ *Id.* at 1027.

⁷⁸ Social Security Act, 42 U.S.C. § 1395rr(a) (2006).

⁷⁹ C. David Flower, *State Discretion in Funding Organ Transplants Under the Medicaid Program: Interpretive Guidelines in Determining the Scope of Mandated Coverage*, 79 MINN. L. REV. 1233, 1236 (1994).

⁸⁰ 42 C.F.R. § 430.0 (2009).

⁸¹ Social Security Act, 42 U.S.C. §§ 1396, 1396a(a) (2006).

⁸² Flower, *supra* note 79, at 1240-41.

⁸³ Social Security Act, 42 U.S.C. § 1396b(i)(1) (2006).

reimburse states for organ transplants unless the state develops written standards for transplant coverage where similarly situated individuals are treated alike and the accessibility of high quality care is maintained.⁸⁴ Whether this statute functions as an express grant of discretion to the states in their decisions to fund organ transplants under Medicaid, or merely sets forth the conditions for federal matching funds in transplant procedures, remains unsettled.⁸⁵ The Eighth Circuit in *Ellis by Ellis v. Patterson* and the Ninth Circuit in *Dexter v. Kirschner* have held that states have complete discretion in choosing whether or not to fund organ transplants within state Medicaid plans.⁸⁶ However, the Fourth Circuit in *Pereira v. Pereira v. Kozlowski* and the Eleventh Circuit in *Pittman by Pope v. Secretary, Florida Department of Health and Rehabilitative Services* have held that states must fund organ transplants that are medically necessary, albeit for different reasons.⁸⁷

In *Ellis*, the Eighth Circuit held Arkansas was not required to fund through Medicaid a liver transplant for a ten-month-old infant suffering from a fatal liver condition.⁸⁸ The court found that the federal organ transplant provision governing payment for organ transplants, 42 U.S.C. § 1396b(i), “can be read as merely laying out additional standards the states must meet to receive federal funds for organ transplants, but the legislative history of the provision reveals that Congress intended the states to have discretion whether to include organ transplants in the Medicaid plans.”⁸⁹ Just as states are permitted to limit other medically necessary services, such as the number of doctor visits or the length of hospital stays, state discretion in funding medical procedures was found to be consistent with an overarching policy to “provide the largest number of necessary medical services to the greatest number of needy people.”⁹⁰ Furthermore, the court

⁸⁴ *Id.*

⁸⁵ Flower, *supra* note 79, at 1246; *see also* Lisa B. Deutsch, *Medicaid Payment for Organ Transplants: The Extent of Mandated Coverage*, 30 COLUM. J.L. & SOC. PROBS. 185, 191, 194 (1997).

⁸⁶ *Ellis ex rel. Ellis v. Patterson*, 859 F.2d 52, 55 (8th Cir. 1988); *Dexter v. Kirschner*, 984 F.2d 979, 983 (9th Cir. 1992).

⁸⁷ *Pereira ex rel. Pereira v. Kozlowski*, 996 F.2d 723, 725 (4th Cir. 1993); *Pittman ex rel. Pope v. Secretary, Fla. Dep’t of Health & Rehabilitative Servs.*, 998 F.2d 887, 891 (11th Cir. 1993).

⁸⁸ *Ellis*, 859 F.2d at 53, 55. By the time that *Ellis* reached the Eighth Circuit, Arkansas was in the process of modifying its state Medicaid criteria to provide additional funding for organ transplants. *Id.* at 56.

⁸⁹ *Id.* at 54-55.

⁹⁰ *Id.*

in *Ellis* determined Congress “did not intend to require states to provide funds for exotic surgeries which, while they might be the individual patient’s only hope for survival, would also have a small chance of success and carry an enormous price tag.”⁹¹

The Ninth Circuit adopted the Eighth Circuit’s line of reasoning and held in *Dexter* that Arizona likewise retained discretionary power to fund autologous bone marrow transplants but not allogenic bone marrow transplants through its Medicaid program.⁹² The same federal statute cited in *Ellis* applicable to payments for organ transplants “does not make payments mandatory [but] . . . states only what must occur in the event a state should decide, in its discretion, to pay for organ transplants.”⁹³ The court in *Dexter* also found compelling the fact that while medical facilities in Arizona could perform autologous bone marrow transplants, no corresponding program for allogenic bone marrow transplants existed in the state at the time.⁹⁴ “Arizona’s decision not to fund the additional expenditures despite the similarity in cost for both types of bone marrow transplants was . . . rational.”⁹⁵

One year later, the Fourth Circuit in *Pereira* expressly rejected the findings of the Eighth and Ninth Circuits and held that Virginia was required to fund medically necessary organ transplants for patients who qualify under Medicaid.⁹⁶ The court rejected “the . . . contention that section 1396b(i)(1) affirmatively confers upon the states the unqualified discretion whether to fund transplants.”⁹⁷ Even if “Congress intended . . . to afford the states absolute discretion whether to fund organ transplants . . . (and there is no evidence in either the statute or its history that this was its intention), it did not embody that intention in statute.”⁹⁸

The Eleventh Circuit in *Pittman* drew the same conclusion as the Fourth Circuit and mandated Medicaid coverage for a fifteen-month-old child’s liver-bowel transplant based on statutory requirements that states provide medically necessary services to children receiving early and periodic screening, diagnostic, and treatment (EPSDT) services under

⁹¹ *Id.*

⁹² *Dexter v. Kirschner*, 984 F.2d 979, 987 (9th Cir. 1992).

⁹³ *Id.* at 983.

⁹⁴ *Id.* at 987.

⁹⁵ *Id.*

⁹⁶ *Pereira ex rel. Pereira v. Kozlowski*, 996 F.2d 723, 726-27 (4th Cir. 1993).

⁹⁷ *Id.* at 725.

⁹⁸ *Id.* at 727.

Medicaid.⁹⁹ Even where courts have granted state discretion in coverage determinations, Medicaid participants under the age of 21 would still be funded for organ transplants since the EPDST program requires coverage for all medically necessary treatment for eligible recipients.¹⁰⁰

2. Arbitrary and Unreasonable Standard

Even in jurisdictions where courts have decided in favor of state discretion in their ability to set their own coverage criteria for funding organ transplants, Medicaid participants nevertheless are protected against standards that result in arbitrary or unreasonable outcomes. A state Medicaid agency “may not arbitrarily deny or reduce the amount, duration or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.”¹⁰¹ “[O]nce a state has adopted a policy to cover a category of organ transplants, it may not arbitrarily or unreasonably deny services to an otherwise eligible Medicaid recipient.”¹⁰²

In *Montoya v. Johnston*,¹⁰³ two plaintiffs aged six months and six years, respectively, could not be listed on the liver transplant waiting list because of a required \$100,000 pre-payment or insurer guarantee of coverage.¹⁰⁴ The children were covered under Medicaid but Texas capped in-patient hospital services at \$50,000 over the course of twelve months.¹⁰⁵ The court held that this state cap violated federal standards which “prohibit the arbitrary and/or unreasonable denial of services to otherwise eligible recipients.”¹⁰⁶ Since the cost of the medically appropriate and non-experimental liver transplants would cost approximately \$200,000, the \$50,000 cap would functionally deny otherwise eligible recipients benefits even though liver transplants are covered under Texas Medicaid.¹⁰⁷ Similarly, the Eighth Circuit in *Ellis* held that any state-imposed cap on funding that would prevent a patient from being listed on a transplant

⁹⁹ *Pittman v. Secretary, Fla. Dep’t of Health & Rehabilitative Servs.*, 998 F.2d 887, 891-92 (11th Cir. 1993).

¹⁰⁰ *Id.*

¹⁰¹ 42 C.F.R. § 440.230(c) (2009).

¹⁰² *Meusberger v. Palmer*, 900 F.2d 1280, 1282 (8th Cir. 1990).

¹⁰³ 654 F. Supp. 511 (W.D. Tex. 1987).

¹⁰⁴ *Id.* at 512.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 514.

¹⁰⁷ *Id.*

waiting list would functionally deprive that patient of the procedure and therefore result in an arbitrary and unreasonable denial of that benefit.¹⁰⁸

In addition to reimbursement caps, plaintiffs have successfully challenged specific state Medicaid criteria for transplant eligibility using the arbitrary and unreasonable standard. Michigan, for example, employed patient selection criteria which required that a prospective liver transplant recipient suffering from alcoholic cirrhosis must have a documented two-year period of abstinence from alcohol.¹⁰⁹ In *Allen v. Mansour*, the court deemed this requirement arbitrary and unreasonable since it would screen “out an entire class of otherwise qualified liver transplant applicants” who would die before completing that two-year period or would develop such severe complications that they would be rendered ineligible for an operation anyway.¹¹⁰ Although the state retained “substantial discretion to choose the proper mix of amounts, scope, and duration limitations for the services offered in its Medicaid plan,”¹¹¹ the court deemed this two-year abstinence requirement as arbitrary due to a lack of expertise on alcoholism and recidivism or statistical data to make a rational and scientific decision on the proper length of an abstinence requirement.¹¹² The court also found significant that “[i]f a potential donee could survive two years without a transplant, the donee did not need the transplant in the first place.”¹¹³

3. Medicare Designations of Experimental or Investigational Treatments

Organ transplantation coverage under Medicare is most frequently invoked by litigants to support or rebut a contention that a specific transplant procedure should be considered experimental or investigational and therefore excluded under most private insurance and government benefit program policies. These insurers may utilize the expert determinations and findings of Medicare’s oversight and quality assurance agency, the Health Care Financing Administration (HCFA), to help define or inform how they view unproven medical technologies or procedures.

For instance, in *Bechtold v. Physicians Health Plan of Northern Indiana, Inc.*,¹¹⁴ the private insurer “chose to link the experimental nature

¹⁰⁸ *Ellis ex rel. Ellis v. Patterson*, 859 F.2d 52, 56 (8th Cir. 1988).

¹⁰⁹ *Allen v. Mansour*, 681 F. Supp. 1232, 1233 (E.D. Mich. 1986).

¹¹⁰ *Id.* at 1235.

¹¹¹ *Id.* at 1237.

¹¹² *Id.* at 1238.

¹¹³ *Id.* at 1235.

¹¹⁴ 19 F.3d 322 (7th Cir. 1994).

of a treatment to the neutral (third party) determination of the medical experts responsible for drafting the HCFA Medicare Coverage Issues Manual.”¹¹⁵ The insurer’s express intent was to avoid resorting to a “case-by-case battle of the experts each time a self-proclaimed ‘expert’ publishes a new article” about a new procedure.¹¹⁶ The court in *Bechtold* allowed the insurer to rely on HCFA opinions to determine whether a procedure should be considered experimental because this deference was unambiguously expressed in the policy language.¹¹⁷

Other courts, however, have looked for reasons to circumvent HCFA classification of experimental procedures. The Third Circuit in *Heasley v. Belden & Blake Corp.*¹¹⁸ explained why reliance on Medicare guidelines could be problematic:

First, the guidelines themselves are, by their terms, directory rather than mandatory... Second, expert witnesses for both sides agreed Medicare relied on dated literature and data in determining the appropriate conditions for coverage of liver transplants... Third, Belden & Blake’s health coverage expert admitted it is “not uncommon in the health care industry” for insurers to approve treatments even though Medicare has not approved them.¹¹⁹

In *Meusberger v. Palmer*, Iowa’s Medicaid agency denied coverage of a participant’s pancreatic transplant because their policy was “to fund only those organ transplants designated non-experimental by Medicare.”¹²⁰ The Eighth Circuit upheld the district court’s holding that reliance on Medicare’s designation of non-experimental was “intended as an administrative convenience rather than an inalterable adherence.”¹²¹ “A state cannot avoid scrutiny and evade review of unreasonable policies by simply delegating absolutely the decision-making to a federal agency charged with a substantially different mission.”¹²² Furthermore, in *Nichols*

¹¹⁵ *Id.* at 326.

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 326-27.

¹¹⁸ 2 F.3d 1249 (3d Cir. 1993).

¹¹⁹ *Id.* at 1261 n.13.

¹²⁰ *Meusberger v. Palmer*, 900 F.2d 1280, 1282 (8th Cir. 1990).

¹²¹ *Id.*

¹²² *Id.* at 1283.

v. Trustmark Insurance Company,¹²³ the court noted that the actual language of the insured's policy granted coverage for "drugs, therapies or other treatments... that are approved for reimbursement by the Health Care Financing Administration."¹²⁴ However, the policy did not specify HCFA approval under Medicare as opposed to Medicaid.¹²⁵ In this case, Ohio's Medicaid policy did cover the insured's high-dose chemotherapy with autologous bone marrow transplant (HDC/ABMT) procedure where the federal Medicare policy did not.¹²⁶

C. INSURANCE COVERAGE FOR DONORS

The medical procedures involved with extracting an organ from a donor for transplantation is considered part of the recipient's overall procedure and is funded as such. Still, insurance coverage becomes a significant issue in the event that a living donor experiences unanticipated post-transplant complications.

Any costs incurred by an organ donor, from medical evaluation and testing to the actual surgery, are covered by the eventual organ recipient.¹²⁷ After an organ donation, the hospital will bill the organ procurement organization, which then bills the recipient or recipient's insurer.¹²⁸ In *Zwerin v. Group Health Incorporated*,¹²⁹ the insurer was obligated to reimburse the costs of tests performed on the insured's sister in the course of an evaluation to determine her suitability as a potential bone marrow transplant donor.¹³⁰ The insurer had claimed that since the sister was not a covered dependent under the insurance policy, her medical tests, "even if for the claimant's benefit or as part of his overall treatment," would be excluded from coverage.¹³¹ The court in *Zwerin*, however, rejected the insurer's "illogical and tenuous position" and instead relied upon the insurance policy's broad provision for the coverage of "general medical

¹²³ 1 F. Supp. 2d 689, (N.D. Ohio 1997).

¹²⁴ *Id.* at 693.

¹²⁵ *Id.* at 696.

¹²⁶ *Id.* at 696-97.

¹²⁷ United Network for Organ Sharing, *supra* note 3.

¹²⁸ David A. Axelrod, et al., *Rates of Solid-Organ Wait-listing, Transplantation, and Survival Among Residents of Rural and Urban Areas*, 299 J. OF AM. MED. ASS'N 643, Jan. 16, 2008.

¹²⁹ 541 N.Y.S.2d 1014 (1989).

¹³⁰ *Id.* at 1015.

¹³¹ *Id.*

care” and “treatment of illness.”¹³² These tests were “a necessary step in exploring the possibility of a bone marrow transplant operation as part of the claimant’s treatment.”¹³³ The insured “is permitted to explore all reasonable avenues of treatment which might arrest and reverse the progress” of his debilitating disease and therefore entitled to recover the costs of the medical tests performed for his benefit.¹³⁴

While the costs of the immediate tests and procedures related to organ donation are funded by the recipient, additional costs incurred as a result of unexpected complications or adverse long-term effects may fall to the living donor. The number of living organ donors have matched or exceeded the number of traditional cadaveric donors since 2001, mostly through directed donations by family members.¹³⁵ The probability of adverse effects continues to be quite low and most complications are minor when they do occur, especially since unlike most surgeries, living organ donors are usually in excellent health before undergoing the operation.

Even so, in an analysis conducted by Seoul National University College of Medicine, the morbidity rate of a specific type of liver transplant, where the right section of the liver of the living donor is extracted, reached a high of 78.3%.¹³⁶ While most of this subset experienced only minor post-operative complications, several patients suffered potentially life-threatening complications which required additional treatment.¹³⁷ Even organ donation through less-invasive laparoscopic procedures versus conventional open operations has its risks. In a medical comparison study of these two technologies, two out of twenty patients who underwent laparoscopic donor nephrectomies still experienced poor oxygen saturation in the immediate postoperative period and unilateral pulmonary congestion.¹³⁸

Despite the low incidence of post-surgical complications for an organ donor, health problems related to but following the actual donation may not be covered by the recipient’s insurer. If a recipient’s insurance policy provides coverage for a limited time but the recipient dies, coverage

¹³² *Id.*

¹³³ *Id.* at 1016.

¹³⁴ *Id.*

¹³⁵ United Network for Organ Sharing, *supra* note 3.

¹³⁶ Kyung-Suk Suh et al., *Three-Quarters of Right Liver Donors Experienced Postoperative Complications*, 13 LIVER TRANSPLANTATION 797 (June 2007).

¹³⁷ *Id.*

¹³⁸ J.R. Waller, *Living kidney donation: a comparison of laparoscopic and conventional open operations*, 78 POSTGRAD. MED. J. 153 (2002).

for the donor may also disappear.¹³⁹ In theory, a kidney transplant donor who suffers the loss of the remaining kidney later in life moves to the top of the transplant waiting list, but the patient must cover the cost of the operation herself, even though the original donation necessitated the second transplant.¹⁴⁰ Other financial expenses, including the personal expenses of travel, housing and lost wages or even the increased difficulty and cost in obtaining health, disability or life insurance, remain the responsibility of the living donor.¹⁴¹

III. UNINTENDED CONSEQUENCES WHEN INSURANCE AND ORGAN TRANSPLANTATION INTERSECT

Insurance intersects with the medical practice of organ transplantation to yield surprising connections beyond the more basic issues of coverage and funding. This section reveals the insurance sector's unintended or unexpected influence in determining which entities or individuals have the opportunity to participate in the organ donation and receipt process.

A. INSURERS MAKE MEDICAL DETERMINATIONS

While assessments of a patient's need for certain procedures seem best left to the expertise of medical practitioners, many of the cases discussed above demonstrate that insurers act at least as a key participant, if not the final arbiter, in the medical decision-making process. Both public and private insurers include explicit requirements of medical necessity for coverage and insert exclusions for procedures considered experimental or investigational. In the field of organ transplantation, these exclusions may serve to preclude reimbursement or access to emerging transplant technologies, like dual organ transplants, or accepted therapies applied for the treatment of certain conditions, such as the use of bone marrow or stem-cell transplants to treat cancer.

Experimental treatment exclusions originally arose out of concerns that procedures have limited or no medical value and that this potentially unnecessary medical care might actually be harmful to patients.¹⁴² Today,

¹³⁹ United Network for Organ Sharing, *supra* note 2.

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² Mark A. Hall and Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1646 (1992).

the economics of health care play a bigger role. “By requiring clinicians to prove that new procedures are efficacious before they are covered, the hope is that existing resources will be better allocated to maximize the health status of the overall population.”¹⁴³ Either way, insurers still act as gatekeepers where medical professionals must petition for the approval of non-medical entities on medical matters.

B. INSURANCE STATUS DETERMINES ACCESS TO DONATED ORGANS

A potential organ recipient’s access to donated organs is determined in large part by the patient’s ability to fund the life-saving transplant procedure through insurance. An uninsured patient or one subject to reimbursement caps may be excluded from a transplant waiting list without a substantial deposit or proof of insurance coverage.¹⁴⁴ More than 99% of organ recipients are covered by insurance at the time of the procedure.¹⁴⁵ Private insurance and Medicare were equally the most common sources of payment for organ recipients at 44.2% each.¹⁴⁶ Only 9% of total organ recipients were covered by Medicaid, even though Medicaid participants comprised 18.5% of the general in-patient population.¹⁴⁷ Consequently, Medicaid organ recipients are less likely to be funded for organ transplants than other procedures requiring hospital admission.¹⁴⁸

While some organ transplant recipients may be funded through specific benefit programs, such as Medicare’s ESRD Program or similar state benefit plans, or through the admirable efforts of transplant social workers and financial coordinators to obtain financing on a patient’s behalf, the highly disproportionate number of insured versus uninsured organ recipients is troubling in a system that is explicitly mandated to ensure equality in access.¹⁴⁹ A ground-breaking 1999 study examining California

¹⁴³ *Id.* at 1639.

¹⁴⁴ *See, e.g., Montoya*, 654 F. Supp. at 512; *Ellis*, 859 F.2d at 56. *But see* *McLaughlin v. Williams*, 801 F. Supp. 633 (S.D. Fla. 1992) (granting motion to require Florida Medicaid agency to provide hospital with financial guarantee required to begin organ search).

¹⁴⁵ Andrew A. Herring et al., *Insurance Status of U.S. Organ Donors and Transplant Recipients: The Uninsured Give But Rarely Receive*, 38 INT’L. J. OF HEALTH SERVICES 641, 644 (2008).

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 645.

ESRD patients revealed for the first time the strong correlation between health insurance status and access to organ transplant procedures.¹⁵⁰ Nearly all ESRD patients are entitled to benefits offered under Medicare's ESRD program, though about 8% of ESRD dialysis patients were ineligible for the program in 1992, the year the analysis was conducted.¹⁵¹ Many of these individuals who lack Medicare coverage are forced to rely on state Medicaid programs for financial support, though beneficiaries must meet financial eligibility criteria first.¹⁵²

The 1999 California study separated all California ESRD patients under the age of 65 into three, mutually exclusive cohorts: Medicaid participants, Medicare participants, and patients enrolled in both Medicaid and Medicare.¹⁵³ Only 31.4% of all Medicaid patients were eventually listed on the OPTN transplant waiting list, compared to 45% of Medicare patients and 38.8% of the dually eligible patients.¹⁵⁴ This disparity is even more exaggerated when examining subsets within these patient cohorts. Only two-thirds of all patients under 15 years old insured by Medicaid were placed on the transplant waiting list while 91.7% of Medicare patients under age 15 were listed.¹⁵⁵

Further examination of pertinent socio-economic factors revealed important differences in the Medicaid patient population. Medicaid participants show a higher incidence of HIV/AIDS, mental illness and non-compliance based on past dialysis attendance, all important considerations which weigh against a patient's eligibility for transplant.¹⁵⁶ They are also "clearly more disadvantaged, less likely to be highly educated, potentially more apprehensive about the transplant procedure, and less assertive about being wait-listed."¹⁵⁷ However, once an ESRD patient makes it onto the transplant waiting list and is entered into the system, insurance status does not influence the receipt of a cadaveric kidney transplant.¹⁵⁸

¹⁵⁰ Mae Thamer et al., *Unequal Access to Cadaveric Kidney Transplantation in California Based on Insurance Status*, 34 HEALTH SERVICES RESEARCH 879, 895 (1999).

¹⁵¹ *Id.* at 880.

¹⁵² *Id.* at 881.

¹⁵³ *Id.*

¹⁵⁴ *Id.* at 886.

¹⁵⁵ *Id.* at 888-89.

¹⁵⁶ Thamer, *supra* note 150, at 897.

¹⁵⁷ *Id.*

¹⁵⁸ *Id.* at 898.

C. INSURANCE COVERAGE PREDICTS WHO WILL DONATE

The extent of coverage also plays a significant role in which individuals are most likely to donate. Unlike presumed consent systems in other countries, primarily in Europe, where an individual is automatically presumed to be a donor unless the individual or a representative opts out, an organ donor in the United States must make an affirmative gift.¹⁵⁹ This reflects the free choice of the individual to elect for donation upon death, and the latest set of revisions to the Uniform Anatomical Gift Act strengthens this right even further by barring others from making a gift after death if the individual donor previously refused.¹⁶⁰

For those who do elect to donate their organs at death, lack of insurance coverage was a stronger predictor for donation than any other characteristic or demographic factor except for age. Americans without health insurance are much more likely to donate a liver or kidney for transplant than to receive one.¹⁶¹ Nearly 17% of organ donors in 2003 lacked health insurance, but only 0.8% of organ recipients are uninsured.¹⁶² Additionally, the percentage for uninsured organ transplant recipients, at 0.8%, is far less than the overall 4.6% uninsured rate for all in-patient hospitalizations.¹⁶³ Since transplantation is markedly different than other procedures in that the operation requires a scarce resource that can only come from other human beings, the pressure for fairness in patient access to this treatment is even more pronounced. Instead, while the uninsured tend to donate organs at relatively high rates, they are much less likely to receive an organ if they are in need of one.

This disparity is noteworthy particularly given that the 47 million Americans without health care tend to suffer from illnesses and conditions that otherwise exclude them from the organ donor pool.¹⁶⁴ The uninsured suffer from higher mortality rates and more restrictive access to preventative and essential care, increasing the rates of chronic disease in this subset.¹⁶⁵ They are less likely to have regular check-ups, less likely to see personal physicians managing their long-term care and less likely to

¹⁵⁹ REVISED UNIFORM ANATOMICAL GIFT ACT, *supra* Note 9.

¹⁶⁰ *Id.*

¹⁶¹ Herring et al., *supra* note 145, at 641.

¹⁶² *Id.*

¹⁶³ *Id.* at 644.

¹⁶⁴ TOM KOCH, SCARCE GOODS: JUSTICE, FAIRNESS AND ORGAN TRANSPLANTATION 139 (2002).

¹⁶⁵ *Id.*

benefit from early diagnosis when diseases are most treatable.¹⁶⁶ Their ability to pay for advanced treatment is also compromised, so that overall, “the uninsured poor are more likely to suffer untreated health problems that will disqualify them medically as donors.”¹⁶⁷ Yet, the opposite is true, that while the health care system “denies adequate care to many of the uninsured during life..., in death, the uninsured often give strangers the ultimate gift.”¹⁶⁸

IV. RECOMMENDATIONS

This last section suggests several options, which address some of the more troubling effects and negative externalities exposed when insurance and organ transplantation intersect. The nature of the public and private insurance sector’s business model presents significant obstacles in obtaining full or even expanded coverage for organ transplantation, since the needs of one insured in need of a transplant must be balanced against the stark economics required to fund health care for the rest. With this in mind, the following recommendations attempt to promote and prioritize efforts to establish greater clarity, consistency and fairness in both the organ donation and transplantation process.

A. CLEAR COVERAGE POLICIES, INFORMED POLICYHOLDERS

Insurance contract language should be drafted with as much clarity as possible to indicate to the policyholder whether organ transplants are covered and if so, the extent of coverage as it relates to the type of procedures and for the treatment of which specific conditions. Undoubtedly, insurers have the right to exclude coverage for certain procedures as long as their exclusionary policies are non-discriminatory, properly disclosed and otherwise consistent with the law. If the insurer elects to incorporate organ transplant exclusions, at the very least “it should do so conspicuously and unambiguously so a reasonable insured can determine this fact by looking at her policy.”¹⁶⁹

Well-drafted insurance policies permit the parties the freedom to fairly contract according to their own terms without the interference of the court system. If confronted with unambiguous policy language, courts

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* at 140.

¹⁶⁸ Herring et al., *supra* note 145, at 645.

¹⁶⁹ *Simkins*, 229 F.3d at 736.

“need not look outside the policy for indications of the intent of the parties.”¹⁷⁰ However, once the court system is brought in to interpret the relevant contract language, courts may “out of deference to treating physicians... refus[e] to respect the mechanism the parties have chosen to define the scope of coverage, forcing them to contract in ways they prefer not to, and even then refusing to enforce the provisions other courts have imposed.”¹⁷¹ The risk of “judge-made insurance” then is that the court’s newly defined parameters of coverage may very well serve to create policies that “informed consumers in the private marketplace would have chosen not to purchase.”¹⁷²

Courts have imposed a higher standard for drafting insurance contracts specifically if such an agreement is considered a contract of adhesion, where a standardized contract is “written entirely by a party with superior bargaining power... [while] the weaker party to an adhesion must ‘take it or leave it’... without an opportunity to bargain.”¹⁷³ Language, and especially exclusionary language where a limitation of coverage may disappoint an insured’s expectations, must be precise, conspicuous and worded in language that is plain and clear.¹⁷⁴ For example, an insurer may be expected to position and format an important exclusion in a way that would attract a reader’s attention and offer proper notification that a procedure may not be covered by the insurance policy.¹⁷⁵

Still, even the best contracting practices will fail to generate completely unambiguous and consistent policy language. Too much precision or specificity only creates complexity and confusion. Using the context of organ transplantation, an insurer pursuing the highest level of

¹⁷⁰ *Wota v. Blue Cross and Blue Shield of Colorado*, 831 P.2d 1307, 1310 (Colo. 1992).

¹⁷¹ Hall and Anderson, *supra* note 142, at 1711. See *Romo v. Amedex Ins. Co.*, 930 So.2d 643 (Fla. Dist. Ct. App. 2006). In *Romo*, the court found cause for claims of promissory estoppel, fraudulent misrepresentation, negligent misrepresentation and negligent procurement of insurance when an insurer refused to provide coverage for an insured’s liver transplant despite an express exclusion. *Id.* The court even allowed a motion to reform the contract to include coverage for organ transplants after the fact, since it was seen that the unilateral mistake by the insured coupled with the inequitable conduct of the insurer resulted in a contract which failed to express the agreement of the parties. *Id.* at 649-50.

¹⁷² Hall and Anderson, *supra* note 142, at 1657.

¹⁷³ *Ponder v. Blue Cross of Southern California*, 145 Cal. App. 3d 709, 718 (Cal. Ct. App. 1983).

¹⁷⁴ *Id.* at 719.

¹⁷⁵ See *id.* at 722.

precision would have to create a “laundry list” of covered services and exclusions, classifying, at a minimum, each type of organ transplant, each condition for which an organ transplant may be used to treat, and each medical procedure or technology employed to execute the transplant.¹⁷⁶ A policy containing all these exponential combinations would result in a “sea of print” where important policy conditions are so densely packed that they could be easily overlooked.¹⁷⁷ Additionally, given the rapid progress of new medical research and technology, detailed lists of inclusions and exclusions would have to be updated constantly to reflect the latest developments.¹⁷⁸

Instead, insurers can more fairly communicate contract terms by including direct information about their coverage decision processes in the policy itself.¹⁷⁹ Policyholders may not understand arguably vague language like “medical necessity” or “experimental” unless they are educated as to how insurers may make these determinations should the need arise. Rather than listing every experimental procedure that falls outside of the policy’s coverage, insurers may supplement general exclusions with greater detail about what the insurer may do to classify a treatment as experimental, such as whether the insurer relies on data in peer-reviewed academic procedures or technology assessments performed by reliable third-party governmental agencies or private organizations.¹⁸⁰

Additionally, insurers as well as employers and associations who maintain health benefit programs for their employees and members should have mechanisms in place which clearly inform policyholders as to their organ transplant coverage, especially if insureds were to lose coverage with the selection of a new insurer or policy. In *Swanson v. Sioux Valley Empire Electric Association*, a member organization was forced to switch to a new health care plan when its previous health insurer sought to raise premiums by 38%.¹⁸¹ The organization informed all its members through direct mailings and member newsletters that the new plan excluded coverage for liver transplants.¹⁸² The plaintiff in *Swanson* therefore could not sustain claims against the association for negligent misrepresentation or

¹⁷⁶ Hall and Anderson, *supra* note 142, at 1685.

¹⁷⁷ Schmidt v. Pacific Mutual Life Ins. Co., 268 Cal. App. 2d 735, 737 (Ct. App. 1st Dist. 1969).

¹⁷⁸ Hall and Anderson, *supra* note 142, at 1684-85.

¹⁷⁹ *Id.* at 1686.

¹⁸⁰ *Id.* at 1687-88.

¹⁸¹ 535 N.W.2d 755, 756 (S.D. 1995).

¹⁸² *Id.* at 757.

a breach of good faith and fair dealing since the organization acted to provide notice of the terms of the new health policy.¹⁸³

B. CONSISTENT MEDICAID COVERAGE OF ORGAN
TRANSPLANTATION

Despite the circuit split over the question of state discretion in the funding of organ transplants under Medicaid, coverage should be required in every state for transplant procedures that are medically necessary, appropriate, and non-experimental. The Eighth and Ninth Circuit decisions in *Ellis* and *Dexter* respectively fail to look to the plain language of the federal Medicaid transplant funding provision under 42 U.S.C. § 1396b(i)(1) or account for the political backdrop and legislative intent when the statute was enacted.¹⁸⁴ In addition, consistency across state borders minimizes existing disparities in access to organ transplants for Medicaid beneficiaries based on state funding criteria.

First, § 1396b(i)(1) only provides that the federal government will not supplement state payments “for organ transplant procedures unless the State plan provides for written standards,” primarily standards to ensure that “similarly situated individuals are treated alike” and that any restrictions imposed are at least “consistent with the accessibility of high quality care to individual eligible for the procedures.”¹⁸⁵ Whether a state has discretion to fund or exclude organ transplants in their programs is a question that lies outside the scope of this statute. Instead, “by its plain terms, the statute simply provides that federal Medicaid payments will not be made for organ transplants unless the state has promulgated the specified written procedures.”¹⁸⁶

Furthermore, the federal transplant funding provision was enacted in 1985 during continuing legislative efforts to expand Medicaid coverage, offering additional services including hospice care, case management services and ventilator care for institutional children.¹⁸⁷ Congress also approved expanded eligibility criteria to extend coverage to individuals who did not qualify previously.¹⁸⁸ Finally, Congress by this time already took steps to address public concerns over the shortage of donor organs and

¹⁸³ *Id.* at 758-59.

¹⁸⁴ Deustch, *supra* note 85, at 200-02; Flower, *supra* note 79, at 1267-69.

¹⁸⁵ 42 U.S.C. § 1396b(i)(1) (2006).

¹⁸⁶ *Periera v. Kozlowski*, 996 F.2d 723, 725 (4th Cir. 1993).

¹⁸⁷ Flower, *supra* note 79, at 1268.

¹⁸⁸ *Id.*

the cost of organ transplants, enacting both NOTA in 1984 and the Omnibus Budget Reconciliation Act (OBRA) in 1986.¹⁸⁹ OBRA extended Medicare coverage for drug therapy related to transplant procedures and required that hospitals which received Medicare funding to encourage organ donation and conform to the appropriate organ procurement protocol.¹⁹⁰ These actions combined “demonstrate a congressional preoccupation with the ability of needy individuals to obtain and pay for transplants and a genuine commitment to facilitating the procedure.”¹⁹¹

The Seventh Circuit in *Miller by Miller v. Whitburn* offers perhaps the best justification for federally mandated coverage of organ transplantation in state Medicaid programs.¹⁹² In *Miller*, the Seventh Circuit argued that reliance on §1396b was inappropriate given that organ transplants that are medically necessary and non-experimental already fall into the mandatory service category of in-patient hospital service, one of seven mandatory medical services a state must provide in order to qualify for federal funding.¹⁹³ Consequently, the Seventh Circuit limited review of Wisconsin’s decision to deny funding for the plaintiff’s liver-bowel transplant only as to whether or not a liver-bowel transplant could be considered a “necessary treatment” if its effectiveness was unproven.¹⁹⁴

C. COURTS SHOULD AVOID MAKING MEDICAL DETERMINATIONS

1. Courts Exhibit Biases and Lack Scientific Expertise to Make Medical Determinations

While the court system provides an important mechanism which works to produce fair results in transplant coverage disputes, judicial review should accord high deference to the insurers who make coverage determinations in consultation with independent medical experts. Because of understandable biases in favor of a plaintiff seeking a life-saving operation, judges are inclined “to adopt every conceivable argument in favor of coverage..., essentially preclud[ing] insurers from exercising any meaningful oversight of medical appropriateness.”¹⁹⁵

¹⁸⁹ *Id.* at 1269.

¹⁹⁰ *Id.*

¹⁹¹ Deutsch, *supra* note 85, at 202.

¹⁹² 10 F.3d 1315 (7th Cir. 1993).

¹⁹³ *Id.* at 1316-17.

¹⁹⁴ *Id.* at 1318.

¹⁹⁵ Hall & Anderson, *supra* note 142, at 1644.

First, courts tend to “balance the equities between the parties in a manner that inevitably favors avoiding the possible loss of life over the insurers’ monetary loss.”¹⁹⁶ It is easy to be influenced by a sympathetic plaintiff who has exhausted all other avenues in the treatment of a serious illness. In *J.D. by Devantier v. Sherman*, the plaintiff was an eight-year-old boy afflicted with a debilitating genetic disorder which could be cured by a liver transplant.¹⁹⁷ However, Missouri Medicaid considered the transplant an elective option rather than a medical necessity since the disease could be managed through careful dietary restrictions.¹⁹⁸ The court in *J.D.* held that “even if it were obvious that the state could save some money by treating, as opposed to curing J.D., the fiscal harm suffered by Missouri Medicaid is outweighed by the harm to J.D. should he not receive a liver transplant.”¹⁹⁹

In addition, judges are forced to rely on expert testimony presented in an adversarial setting that often devolves into a battle of the experts. In this scenario, experts do not present objective and balanced scientific perspectives focused on truth-finding and accuracy, but rather introduce arguments most persuasive in supporting their party’s side.²⁰⁰ The Seventh Circuit in *Bechtold* proposes an interesting alternative:

In order to resolve the question of whether health insurance providers should cover treatments..., the prudent course of action might be to establish some sort of regional cooperative committees comprised of oncologists, internists, surgeons, experts in medical ethics, medical school administrators, economists, *representatives of the insurance industry*, patient advocates and politicians. Through such a collective task force perhaps some consensus might be reached concerning the definition of experimental procedures, as well as agreement on the procedures, which are so cost prohibitive that requiring insurers to cover them might result in the collapse of the healthcare industry. While such a committee would in no way be a panacea for our skyrocketing health care costs, it may help to reduce the incidence of suits in which one

¹⁹⁶ *Id.* at 1655.

¹⁹⁷ No. 06-4153-CV-C-NKL, 2006 WL 3163053, at *1 (W.D. Mo. Oct. 27, 2006).

¹⁹⁸ *Id.*, at *1.

¹⁹⁹ *Id.*, at *8.

²⁰⁰ Hall & Anderson, *supra* note 142, at 1675.

“expert” testifies that a procedure is experimental and another equally qualified “expert” testifies to the opposite effect. This so called battle of the experts occurs all too frequently in federal court.²⁰¹

But are insurers capable of making educated, independent assessments of medical necessity when those same companies profit from avoiding payment of claims? In order to minimize conflicts of interest, the insurance sector should make sure to engage outside independent medical experts for consultation before making determinations of medical necessity.²⁰² These consultants help assure neutrality in the decision-making process, particularly if practitioners are compensated in a manner that does not reward or incentivize the number of claim denials.

2. Coverage of HDC/ABMT

There is perhaps no better example of court interference in medical decisioning than the substantial case law surrounding high-dose chemotherapy with autologous bone marrow transplant (HDC/ABMT) as a last resort treatment for cancer.²⁰³ During HDC/ABMT, a patient’s bone marrow cells are extracted and stored temporarily before the patient undergoes high-dose chemotherapy, after which the stored cells are transplanted back into the patient to counter the toxic effects of the chemotherapy.²⁰⁴ While Phase II clinical studies supported the use of this procedure at the time, many insurers refused to pay for the treatment based on exclusions for experimental procedures, since there was a lack of evidence that HDC/ABMT was superior to chemotherapy alone or safe and effective in its own right.²⁰⁵ Denials of coverage led to intense litigation

²⁰¹ *Bechtold v. Physicians Health Plan of N. Ind., Inc.*, 19 F.3d 322, 328 (7th Cir. 1994) (emphasis added).

²⁰² *See Hall & Anderson, supra* note 142, at 1670.

²⁰³ Note that the court in *Lubeznik v. HealthChicago, Inc.*, 644 N.E.2d 777 (Ill. App. Ct. 1994), treats HDCT/ABMT not as an organ transplant but a rescue operation, because unlike these treatments, a transplant in which something is taken from one patient and given to another. *Id.* at 781.

²⁰⁴ *O’Rourke v. Access Health, Inc.*, 668 N.E.2d 214, 217 n.1 (Ill. App. Ct. 1996).

²⁰⁵ Peter D. Jacobson & Stefanie A. Doeblor, “*We Were All Sold a Bill of Goods: Litigating the Science of Breast Cancer Treatment*,” 52 WAYNE L.REV. 43, 51 (2006).

and lobbying which in turn led to “unpredictable and inconsistent” court decisions about coverage.²⁰⁶

Rather than fight litigants in this arena, insurers instead quietly decided to include HDC/ABMT as a covered service anyway despite their own misgivings about the efficacy of the treatment.²⁰⁷ This trend was due in large part to the courts’ readiness to regard HDC/ABMT as the legal standard of care.²⁰⁸ To be fair, both sides could validly argue for and against the suggestion that HDC/ABMT represented the standard of care for the treatment of breast cancer.²⁰⁹ The procedure was indeed used to treat more than 30,000 women before studies discounting HDC/ABMT were published, showing the “medical community’s inability to control the procedure’s diffusion.”²¹⁰ Still, the courts often succumbed to the more emotional appeals of plaintiffs desperate for this treatment and discounted medical expert after medical expert presented by defendant-insurers.²¹¹

Had the courts, for instance, adopted a standard based on what a reasonable managed care organization would have decided..., the result may have been entirely different. Taking this approach could have had the salutary effect of compelling a more productive dialogue between physicians and plans, along with accelerating the clinical trials process.²¹²

D. CONTINUING COVERAGE FOR ORGAN RECIPIENTS

Insurance coverage for organ transplants should extend beyond the transplant operation itself to include continuing coverage for follow-up care and immunosuppressive drug therapies required to protect rejection of the

²⁰⁶ *Id.* at 52.

²⁰⁷ *Id.*

²⁰⁸ *Id.* at 78.

²⁰⁹ *Id.*

²¹⁰ *Id.* at 45, 111.

²¹¹ *See, e.g., Kulakowski v. Rochester Hosp. Svc. Corp.*, 779 F. Supp. 710 (W.D.N.Y. 1991). In *Kulakowski*, the insurer presented the testimony of the insurer’s medical director, a registered nurse who worked as a medical affairs administrator, the vice-president for Medical Affairs of BCBS of the Rochester area and an oncologist recognized for his expertise in the field of breast cancer. *Id.* at 713. The plaintiff presented only the testimony of the plaintiff’s treating physician. *Id.*

²¹² Jacobson & Doeblner, *supra* note 205, at 80.

transplanted organ. While courts have found prohibitively low insurance caps to be arbitrary or unreasonable,²¹³ insurance coverage could still be limited based on the specific procedure, treatment or total amount of subsidized drugs per year. Medicare, for example, currently covers the cost of anti-rejection drugs for participants only 36 months after transplant even though it fully funds the cost of the transplant itself.²¹⁴

These restrictions yield particularly harsh results on organ recipients who may receive transplants at a young age. Younger recipients have a longer lifespan during which to maintain the costs of on-going care, since they must be medicated against organ rejection for the rest of their lives.²¹⁵ Pediatric patients could lose coverage once their plans expire or when the patient becomes an adult.²¹⁶ Additionally, subsequent coverage may be difficult to obtain as an organ transplant is considered a pre-existing condition.²¹⁷ Some states offer high-risk insurance pools which guarantee coverage regardless of prior medical history, but such coverage varies widely by state and premiums remain 50% to 200% higher with more restricted benefits than the more traditional insurance options available.²¹⁸

According to a recent study in *Pediatric Transplantation*, young transplant recipients who lose their insurance coverage are more likely to stop taking anti-rejection drugs.²¹⁹ Transplant recipients between the ages

²¹³ See, e.g. *Montoya v. Johnston*, 654 F. Supp. 511, 512 (W.D. Tex. 1987); *Ellis v. Patterson*, 859 F.2d 52, 56 (8th Cir. 1988).

²¹⁴ Kevin Sack, *U.S. Cost-Saving Policy Forces New Kidney Transplant*, N.Y. TIMES, Sep. 14, 2009, at A12. According to the Congressional Budget Office, unlimited coverage would add \$100 million a year to the \$23 billion Medicare ESRD program based on the average expenditure of \$17,000 a year on anti-rejection drugs for kidney transplant recipients. *Id.* However, that compares with \$71,000 a year for dialysis patients and \$106,000 for a kidney transplant. *Id.* Both the Senate and House of Representatives have introduced bills to “provide continued entitlement to coverage for immunosuppressive drugs furnished to beneficiaries under the Medicare Program that have received a kidney transplant and whose entitlement to coverage would otherwise expire.” S.565, 111th Cong. (2009). See also, H.R. 1458, 111th Cong. (2009).

²¹⁵ Lisa M. Willoughby et al., *Health Insurance Considerations For Adolescent Transplant Recipients As They Transition to Adulthood*, 11 PEDIATRIC TRANSPLANTATION 127 (Mar. 2007).

²¹⁶ United Network for Organ Sharing, *supra* note 2.

²¹⁷ *Id.*

²¹⁸ PEGGY ROSSI, CASE MANAGEMENT IN HEALTH CARE: A PRACTICAL GUIDE 541.

²¹⁹ Willoughby, *supra* note 210, at 128.

of eighteen and twenty-three years face the greatest risk, since one-third of this subset lacks coverage to begin with.²²⁰ Even if pediatric transplant recipients are insured, coverage is likely to run out 36-44 months after the transplant or when the child becomes an adult.²²¹ In a study of 1,001 children who underwent kidney transplants between 1995 and 2001, one-half lacked insurance coverage and experienced a nine times greater chance of organ failure and death.²²²

Whether payment is from private insurance, Medicaid, or Medicare, almost all providers discontinue insurance coverage for health care and immunosuppressive medications as these young people complete school and leave their parent's care. These patients are frequently faced with the challenges of transition to independent life, changing from pediatric to adult transplant centers, with no clear means of payment for their expensive care and medications.²²³

Even if an organ transplant recipient funds the actual procedure without insurance reimbursement, the Seventh Circuit held that an insurer can deny coverage for subsequent expenses connected to an underlying illness or procedure that was not covered in the first place.²²⁴ In *Loyola University of Chicago v. Humana Insurance Company*, in the middle of cardiac bypass surgery, the insured's heart surgeon decided to insert a Jarvik-7 artificial heart once it was determined that the patient could not survive the operation otherwise.²²⁵ The artificial heart would serve to prolong the patient's life until a suitable organ donor could be found.²²⁶ The insurer, however, denied coverage for all expenses after the insertion of the artificial heart, including the subsequent human heart transplant one month later, because it believed all following expenses were connected to the experimental procedure and therefore excluded by the policy.²²⁷

²²⁰ *Id.*

²²¹ *Id.*

²²² *Id.* at 129.

²²³ Mark Benfield, *Insurance, non-adherence – A call to action*, 11 PEDIATRIC TRANSPLANTATION 236, 236 (2007).

²²⁴ *Loyola Univ. of Chicago v. Humana Ins. Co.*, 996 F.2d 895, 903 (7th Cir. 1993).

²²⁵ *Id.* at 896-97.

²²⁶ *Id.*

²²⁷ *Id.* at 897.

The court agreed with the insurer's refusal of coverage.²²⁸ While the policy ordinarily covers expenses connected to a major organ transplant, an exclusionary clause stated that "no benefit is payable for or in connection with a major transplant" if the coverage for the original transplant is denied based on the procedure's experimental nature.²²⁹ The Seventh Circuit admits that its decision could seem "callous," essentially finding the insurer is justified in refusing coverage because the patient "should be dead."²³⁰

It is unfortunate that a transplant recipient's insured status impacts the sustainability of a donated organ so directly, especially since post-transplant mortality rates otherwise are extremely low.²³¹ In the event of organ failure, a transplant recipient must be placed back on the waiting list for retransplantation. From 1995 to 2005, retransplant candidates represented 13.5%, 7.9%, 4.2% and 5.5% of all newly registered candidates on the kidney, liver, heart and lung transplant waiting lists respectively.²³² In addition, the survival rates for repeat transplants are much lower than the rates for first-time transplantation.²³³ Since re-transplantation increases the overall demand for an already scarce supply of donated organs, and the benefits for repeat transplant patients are so limited, resources are better allocated if the original organ transplantation procedure is given the best possible chance to succeed.

E. CONTINUING COVERAGE FOR ORGAN DONORS, REMOVE DISINCENTIVES

Despite the rarity of post-transplant complications, living donors who are generous enough to donate an organ for the benefit of another should be protected from any adverse results post-donation. Organ donors may face many of the same concerns as organ recipients. In one study sampling a subset of living organ donors, 29% of donors had concerns about financial repercussions from time missed from work, while 2% worried about job security and another 2% reported anxiety about future

²²⁸ *Id.* at 898.

²²⁹ *Id.* at 903.

²³⁰ *Loyola Univ. of Chicago*, 996 F.2d at 903.

²³¹ *Id.*

²³² J.C. Magee, et al., *Repeat Organ Transplantation in the United States, 1996–2005*, 7 AM. J. OF TRANSPLANTATION 1424 (2007).

²³³ *Id.* at 1424.

health insurance coverage.²³⁴ Prospective donors who ultimately did not donate reported similar concerns.²³⁵ Addressing these concerns would not only satisfy a degree of moral or ethical responsibility we owe to organ donors for their own sacrifice, but would minimize some of the disincentives which affect a potential donor's willingness to donate as well.

At the same time, any actions taken to assist organ donors must strike a delicate balance between removing disincentives and providing a form of remuneration. First, according to NOTA, the acquisition of human organs for valuable consideration is illegal.²³⁶ In addition, the use of incentives or a more deliberate move to an organ market system would generate unintended but harmful consequences that would undercut any short-term increase in the total organ supply. In a study of both paid and unpaid blood donation, Antonio Fernandez-Montoya references continuing donor concerns in Spain, where 20% of blood donors still fear the possibility of commercial exploitation even twenty years after the switch from a paid donation model.²³⁷ Even a small decrease in the number of donors repelled by the notion of payment in a traditionally voluntary blood donation system "would severely compromise the service" given that donor numbers are so hard to maintain now.²³⁸ A paid donation model also creates greater vulnerability in the system through decreased safety and quality in the supply of donated blood or organs. Paid donors are often "poorly monitored, belong to lower social classes and often malnourished."²³⁹ They tend to donate in inferior sanitary conditions and experience higher rates of transmittable disease.²⁴⁰ All parties in the transplant infrastructure must then assume additional risk and expenses that come with managing higher-risk donations, including increased monitoring and testing as well as liability issues if contaminated organs are mistakenly transferred to recipients.

Instead, we should consider longer-term donor health insurance as part of "a package of benefits that would not enrich anyone... but rather is designed to leave the donor as well off (fiscally and physically) as before

²³⁴ R.S. Gaston, *Limiting Financial Disincentives in Live Organ Donation: A Rational Solution to the Kidney Shortage*, 6 AM. J. OF TRANSPLANTATION 2548, 2550 (2006).

²³⁵ *Id.*

²³⁶ 42 U.S.C. § 274(e).

²³⁷ Antonio Fernández-Montoya, *Altruism and Payment in Blood Donation*, 18 TRANSFUSION SCI. 379, 383 (1997).

²³⁸ *Id.* at 383.

²³⁹ *Id.*

²⁴⁰ *Id.*

donation.”²⁴¹ To offset the slight but present risk of medical complications after donation, donors should be insured against catastrophic medical expenses which may occur as a result of organ donation. This specific type of supplemental, non-transferrable policy would be designed solely to cover any gaps in an insured’s existing coverage should problems arise in the future.²⁴²

As one option, Medicare’s existing ESRD program could be modified to allow coverage for kidney donors as well as patients suffering from renal disease. A 2006 analysis in the *American Journal of Transplantation* calculated the estimated cost of this additional coverage.²⁴³ Given that the current median donor age is 40 years, on average, Medicare would have to fund benefits until the donor reaches age 65, the standard age that all citizens become eligible for Medicare²⁴⁴. The projected cost of extended coverage based on the current cost of coverage for disabled beneficiaries is \$18,124, but since many donors already have private insurance and represent an extremely healthy segment of the general population, actual costs will be much less.²⁴⁵ Additionally, with benefits targeted to cover only donation-related complications, the comparatively small number of donors, and the rarity of adverse outcomes post-donation, the final amount is a small price to pay to ensure living donors are protected well after their donation.

CONCLUSION

When insurance and organ transplantation intersect, the most essential principles of both fields collide. Insurance requires a sense of objectivity and steadfast adherence to policies that serve to sustain its own survival in economic reality, where the decision to fund one patient’s life-saving operation will force trade-offs in coverage for the rest of the insured base. Meanwhile, the practice of organ transplantation necessitates a more emotional appeal to the values that we admire most in society - qualities of altruism and gratitude at the foundation of how our donative process functions. The by-products of the ensuing clash are real, definable and quantifiable. By recognizing how insurance impacts the practice of organ transplantation, we may start to salvage the more damaging components of

²⁴¹ Gaston et. al., *supra* note 234, at 2550.

²⁴² *Id.* at 2551.

²⁴³ *Id.* at 2552.

²⁴⁴ *Id.*

²⁴⁵ *Id.*

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the relationship and reinforce the ways in which the two fields complement each other.

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